		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE COMPL	
		155458	A. BUII B. WIN			05/20/2	011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		9630 FI	ADDRESS, CITY, STATE, ZIP CODE IFTH ST AND, IN46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0000							
	This visit was for a Recertification and State Licensure Survey.		FO	0000			
		ny 16, 17, 18, 19 and 20,					
	Facility number:						
	Provider number:	: 155458					
	AIM number: 100289280						
	Survey team: Kathleen (Kitty) Lara Richards, R Heather Tuttle, R Janet Adams, RN Census bed type:	N N					
	SNF/NF: 29						
	Total: 29						
	Census payor typ Medicare: 6 Medicaid: 18 Other: 5 Total: 29	e:					
	Stage II Sample:	25					
		es reflect state findings ce with 410 IAC 16.2.					
	Quality review comp	pleted on May 26, 2011 by					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1XZS11

Facility ID:

000367

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	onstruction 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155458	A. BUILDING		05/20/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			FTH ST	
		REHABILITATION CENTER	HIGHLA	AND, IN46322	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	Bev Faulkner, RN				
	,				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155458	A. BUII			05/20/20	011 l
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
1110111 44	ID NILIDOING AND	DELLA DIL ITATIONI OFNITED		1	FTH ST		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0156	The facility must in	nform the resident both					
SS=E	•	g in a language that the					
		nds of his or her rights and					
		ations governing resident					
		onsibilities during the stay in					
		acility must also provide the					
		notice (if any) of the State §1919(e)(6) of the Act. Such					
		e made prior to or upon					
		ring the resident's stay.					
		formation, and any					
		must be acknowledged in					
	writing.	·					
	,	nform each resident who is					
		id benefits, in writing, at the					
		to the nursing facility or,					
		becomes eligible for					
		ems and services that are					
		g facility services under the which the resident may not					
		other items and services					
	_	ers and for which the					
	•	harged, and the amount of					
		services; and inform each					
		anges are made to the items					
		ified in paragraphs (5)(i)(A)					
	and (B) of this sec	etion.					
		nform each resident before,					
		dmission, and periodically					
		t's stay, of services					
		cility and of charges for					
		cluding any charges for					
		red under Medicare or by					
	the facility's per di	ciii iale.					
	The facility must for	urnish a written description					
	of legal rights which						
		e manner of protecting					
	·	nder paragraph (c) of this					
	section;	,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/20/2	ETED	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET A	ADDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	procedures for es Medicaid, includin assessment unde determines the ex non-exempt resou institutionalization community spous resources which cavailable for payminstitutionalized spor her process of eligibility levels. A posting of name telephone number advocacy groups and certification a office, the State oprotection and add Medicaid fraud contact the resident in State survey and concerning reside misappropriation of facility, and non-codirectives requirements specific facility must be requirements specific facility must be requirements of this chapter relapolicies and procedirectives. These provisions to information to all at the right to accept surgical treatment option, formulate a includes a written	arces at the time of and attributes to the e an equitable share of cannot be considered nent toward the cost of the couse's medical care in his spending down to Medicaid as, addresses, and as of all pertinent State client such as the State survey gency, the State licensure mbudsman program, the vocacy network, and the ntrol unit; and a statement may file a complaint with the certification agency and the compliance with the advance ments. Somply with the cified in subpart I of part 489 ated to maintaining written adures regarding advance requirements include and provide written adult residents concerning are or refuse medical or and, at the individual's an advance directive. This description of the facility's ent advance directives and					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULT A. BUILDI B. WING		STRUCTION 00	(X3) DATE S COMPL 05/20/2	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9	9630 FIF	DDRESS, CITY, STATE, ZIP CODE TH ST ND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	name, specialty, a physician response. The facility must proceed facility written informand use Medicare how to receive refrowered by such the facility faile residents whose accounts were written notificate chargeable iter. The facility also residents reviet the discontinual received timely end of services #26, #28 and #Findings included. 1. Interview with family member they had not rewished they had not rewished they had not rewished the A aware if the residented a list of the received and the received a list of the received and the received a list of the received and the received a list of the received a list	rd review and interview, d to ensure 4 of 4 se resident trust reviewed, received cion of a list of ms upon admission. o failed to ensure 1 of 3 wed for notification of ation of skilled services, r notification prior to the s. (Residents #7, #21,	F015	66	Preparation and/or execution this plan does not constitute admission or agreement by the provider of the truth of the far alleged or conclusions set for on the statement of deficients. This plan of correction is prepared and/or executed so because required. F 156 Result of facility a. What corrective action(s) will be accomplished those residents found to have been affected by the practice: Issue # 1 - Residen 26, 21, 28, and 35 were prowed with written notification of a lichargeable items, including was covered by Medicaid and Medicare. Issue # 2 - Residen 7's responsible party was given ontice of non-coverage and in not chosen to appeal the coverage determination. The and NHA were given a teach moment regarding the facility "Notice of Medicare Provider Non-Coverage "standard and guideline. b. How you will identify other residents have	he cts rth cies. olely sident et # rided ist of what d/or ent # reas e SSD able r's et d	06/19/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CON	NSTRUCTION	(X3) DATE SU COMPLET		
AND PLAIN	OF CORRECTION	155458	A. BUILI	DING	00	05/20/20 ²	
		133436	B. WING	_		03/20/20	11
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LUCLUAN	ID NI IDOING AND	DELIABII ITATIONI CENTED		9630 FIF			
HIGHLAI		REHABILITATION CENTER		ПІСПІАІ	ND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	<u> </u>		DATE
	rate.				potential to be affected by t same practice and what	ne	
					corrective action will be tak	en.	
		he Administrator on			Issue # 1 –An audit of curre		
		a.m., indicated the			residents was completed to		
	· · · · · · · · · · · · · · · · · · ·	y did not receive a			ensure were provided with w		
	schedule of cha	arges from the facility.			notification of a list of charge	able	
					items, including what was covered by Medicaid and/or		
		e resident funds			Medicare. Issue # 2 – All		
		19/11 at 2:00 p.m.,			residents currently residing in	n the	
		ent #21 was admitted			facility that have been discha	arged	
to the facility on 2/28/11, Resident					from Medicare Part A service		
#28 was admitted to the facility on				the last 30-day were reviewe			
	11/26/10 and Resident #35 was				ensure appropriate receipt an completion of the SNFABN c		
	admitted to the	facility on 2/15/11.			be evidence in the resident's		
					medical record. Anyone iden	I .	
	There was no c	locumentation to			as not having appropriately		
	indicate if the a	bove residents			received the SNFABN the		
	received a sche	edule of charges			appropriate option boxes will their rights explained and rec		
	indicating what	was covered by			a new SNFABN form. c. Wh		
	Medicare and/o	or Medicaid services.			measures will be put into p		
					or what systematic changes		
	Interview with t	he Administrator on			you will make to ensure tha		
	5/20/11 at 8:08	a.m., indicated the			the practice does not recur		
	residents did no	ot receive a schedule			The facility's administrative s		
		the facility at the time			were re-educated by the Reg A/R Analyst on the compone		
	of admission.				this regulation with emphasis		
					on:S & G on Business Office		
					ReviewS & G Admission Fold	der	
					List Standard and Guideline		
					regarding: Notice for Discontinuation of Skilled		
					Services (SNFABN Notice		
					(CMS-10055, Medicare Prov	ider	
					Non-Coverage (CMS -1023)	and	
					Detailed Explanation Covera	-	
					(CMS -10124) in detail with t	ne	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155458	A. BUILDING		05/20/2011
		100400	B. WING		00/20/2011
NAME OF F	ROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
LUCLUAN	ID NI IDOING AND I	DELIADU ITATION CENTED	I	FTH ST	
HIGHLAI	ND NURSING AND	REHABILITATION CENTER	HIGHLA	AND, IN46322	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	appropriate department head who have the responsibility to explain and complete these fand/or issue to the resident's qualify of receipt of said form. The Medicare Claims Proces manual, Chapter 30 as it per to issuance of the SNFABN a completion of the overall form. The BOM/designee will bring daily audit of admission packets to AM meeting and r NHA of any outstanding packets The SSD will review Notice for Discontinuation of Skilled Services at the weekl meeting for appropriateness dates. d. How the correctivaction(s) will be monitored ensure the practice will not recur, i.e., what quality assurance program will be into place: The NHA or designee will review each ne admission to ensure they we issued a notification of a list of chargeable items, including was covered by Medicaid and Medicare. These audits will be completed for the next four was	ds of corms that s. ssing tains and the cotify the stoop of cotify the stoop of cotify the cotification that the cotification that the cotification the cotification that the cotification
				then monthly times 2 months determine if substantial	to
				compliance is achieved. The MDSC or designee will monit	tor
				weekly for the next 4 weeks	
				2 times monthly for 2 months	·
				the SNFABN process as it	
				pertains to issuance of the	
				SNFABN and completion of t	he
				overall form.Report of these	
				findings will be presented at monthly Risk Management/C	
				monthly ixiak Management	<i>(</i> 7

000367

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	ı	LETED
		155458	B. WING		- 05/20/	2011
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COI	DE .	
				FIFTH ST		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER	HIGH	_AND, IN46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		<u> </u>	DATE
TAG	3. On 5/18/11, 1 list of residents were discontinulisted as having discontinued or The Administrathe "Notice of Non-Coverage" The form was a Social Service the resident wa 9:00 a.m. that is services would indicated the regranddaughter 2/28/11 at 10:00	tor provided a copy of Medicare Provider ' form for Resident #7. completed by the Director. He indicated as notified on 2/28/11 at her last day of skilled be 3/1/11. He also esident's was notified on 0 a.m. that the day of skilled services	TAG	meeting to determine it compliance has been ringuarterly oversight will completed by the Regi Analyst.e. Date of cor 6/19/11	f met, and l be onal Field	DATE
	and dated 11/1 the Administrate	of Skilled Services" 2/07, was provided by or on 5/18/11 at 5:05 ed the policy was				
	The facility will of the Medicare Non-Coverage					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458			(X2) MULTIPLE CO A. BUILDING B. WING	00	l` ´	e survey pleted /2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 F	ADDRESS, CITY, STATE, ZIP (IFTH ST AND, IN46322	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	than 2 days be skilled services When interview p.m., the Admir	red on 5/18/11 at 4:55 nistrator indicated the				
	the resident and in a timely man	' form was not given to d the responsible party ner. He indicated it en given 2 days prior				
	3.1-4(a) 3.1-4(f)(1)(A)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/20/2	ETED	
	ROVIDER OR SUPPLIER		p. wiiv	STREET A		<u> </u>	
		REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		prization of a resident, the		IAG	Diricilité 1 y		DATE
F0159 SS=A	facility must hold, account for the pe	safeguard, manage, and rsonal funds of the resident facility, as specified in					
	personal funds in a bearing account (or from any of the fact and that credits all resident's funds to accounts, there maccounting for each account of the facility must make the personal funds that	eposit any resident's excess of \$50 in an interest or accounts) that is separate cility's operating accounts, interest earned on that account. (In pooled ust be a separate ch resident's share.) maintain a resident's at do not exceed \$50 in a ang account, interest-bearing					
	system that assure separate accounting accepted accounting resident's personal facility on the resident	establish and maintain a es a full and complete and ng, according to generally ng principles, of each I funds entrusted to the dent's behalf.					
	of resident funds v	oreclude any commingling vith facility funds or with the on other than another					
	available through	ncial record must be quarterly statements and on dent or his or her legal					
	receives Medicaid in the resident's act than the SSI resou	otify each resident that benefits when the amount count reaches \$200 less arce limit for one person, in 1611(a)(3)(B) of the Act;					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155458	B. WIN			05/20/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8		9630 FI			
	ND NURSING AND	REHABILITATION CENTER			AND, IN46322		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`			CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	_	TAG DEFICIENCY)		DATE	
TAG	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		F0159		Preparation and/or execution of this plan not constitute admission or agreement b provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-159 Facility Management of Personal Funds (a) What corrective action(s) be accomplished for those resid found to have been affected by practice: Residents who have personal furaccounts with this facility (that alert) along with responsible paratice, poAs, Guardians, etc.), we given a statement of their person funds with include their interest allocation. BOM has received a teachable	ion and/or execution of this plan does titute admission or agreement by the of the truth of the facts alleged or ons set forth on the statement of cies. This plan of correction is and/or executed solely because Facility Management of al Funds What corrective action(s) will omplished for those residents to have been affected by the e: Ints who have personal fund the with this facility (that are long with responsible parties OAs, Guardians, etc.), were a statement of their personal with include their interest ion.	
		the Administrator on a.m., indicated the			the quarterly fund/interest states		
	facility does se statements, ho Office Manage	nd out quarterly wever, the Business r was on vacation and cate the quarterly			(b) How you will identify of residents having potential to be affected by the same practice as what corrective action will be taken: Review was completed to identify residents who have personal fur accounts with this facility so the current quarterly statement could provided to all — including	e and ify ad at a	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2011
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND F	REHABILITATION CENTER	STREET A 9630 FI	AND, IN46322	
PREFIX (EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE COMPLETION DATE
			(c) What measures will be into place or what systemath changes you will make to est that the practice does not result to ensure the programment of quarterly into statements. Review of the Standard and Guidelines for Management Resident Funds was review current BOM and Administration of the corrective as will be monitored to ensure practice will not recur, i.e., quality assurance programment into place: The Corporate A/R Analyst designee will review the Restruct to ensure the residents is allocated by the 15th of emonth and that statements a generated and issued quarte each participating resident as responsible party. The Business Office Manage designee will review each nadmitted resident's record for authorization for the facility manage their account. The Facility Risk Manager report results at the next QA Management meeting and not the reafter until substantial compliance has been achieved has been recommended quarted.	ce put tic insure recur: ave been ents of is on the erest cof with rator. ction(s) e the what i will be or sident interest ach re rly to and/or er or ewly or written or to will a/Risk nonthly red and it

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ND IC	00	COMPL	ETED
		155458	A. BUILI		-	05/20/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
	ID AILIDOING AND	DELLA DIL ITATIONI OFNITED		9630 FII			
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		HIGHLA	ND, IN46322		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
			İ	i	monitoring to maintain complia	ince	
					(e) Date of Compliance: 6/19/2	2011	
				1			
F0223		he right to be free from					
SS=D		ysical, and mental abuse,					
		ent, and involuntary					
	seclusion.						
	Th - f::::	-t					
	_	ot use verbal, mental,					
	sexual, or physica	oluntary seclusion.					
		view and interview, the	F02	22	Preparation and/or execution of this plan	n does	06/19/2011
		ure residents remained free	F 02	.23	not constitute admission or agreement b	y the	00/19/2011
	-	lated to inappropriate			provider of the truth of the facts alleged		
		y a staff member to a			conclusions set forth on the statement of deficiencies. This plan of correction is	ĺ	
		allegations of abuse			prepared and/or executed solely because		
	reviewed. (Reside	ent #19) (RN #1)			required.		
	Eta alta ara ta alcuda e				F 222 A1		
	Findings include:				F-223 Abuse	:11	
	The investigation of	f an allegation of abuse for			(a) What corrective action(s)		
	_	reviewed on 5/19/11 at 10:32			be accomplished for those resid found to have been affected by		
		occurred on 3/30/11. The			practice:	uie	
	investigation indica	ted an employee heard RN			Resident #19's allegations were	,	
		dent "you s pants all the			reported to IDOH as required or		
		no one is stopping you." The			03/30/11.		
		actions included suspension			RN #1 no longer works at the fa	acility	
	,	sician and family notification ophysical or emotional			Resident #32 allegations of rough	-	
	injuries/ distress no				treatment were reported to IDO	-	
	injunes/ distress no	ned.			5/19/11		
	The facility investig	ation included interviews			The Social Service Director was	s	
		r residents. The resident			reeducated on the facility standa		
	interviews were obt	tained on 4/4/11. The Social			and guidelines for reporting abu		
		nterviews from four other			neglect and exploitation.		
		he interviews indicated			•		
		ated another staff member			(b) How you will identify ot	her	
		There was no follow up			residents having potential to b	e	
	the investigation.	e statement obtained during			affected by the same practice a	and	
	are investigation.				what corrective action will be		
	The record for Res	ident #19 was reviewed on			taken:		

000367

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
		155458	A. BUILDING		05/20/2011
		100.100	B. WING		00/20/2011
NAME OF I	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
			9630 F	IFTH ST	
HIGHLA	ND NURSING AND	REHABILITATION CENTER	HIGHL	AND, IN46322	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	5/19/11 at 1:13 p.r	m. The resident's diagnoses		Residents who are cognitively	intact
		not limited to, severe		were interviewed to determine	; if any
		thritis, and severe dysphagia		allegations of abuse/neglect ha	ad not
		order). The 5/4/11 Minimum		been reported to facility staff a	ınd
		uarterly assessment indicated		reported according to the facil	ity
		hort and long term memory		standard and guidelines and no	-
		difficulty with making		were reported	
		ituations. The assessment			
		resident required total		(c) What measures will be	nut
	assistance with pe	ersonar nyglene.		into place or what systematic	^ I
	When interviewed	d on 5/19/11 at 12:20 p.m., the		changes you will make to ens	•
		g indicated the RN was		that the practice does not rec	•
	1	time and the RN came in the		The Social Service Director or	
	1 '	resigned. The Director of		Designee will meet bi-weekly	
		she was not aware of the		the Resident Council to ensure	•
		by the other resident that		allegations of abuse, neglect, a	- I
		during the investigation.		exploitation are brought to the	•
		-		Administrator and Risk Manag	
	When interviewed	on 5/19/11 at 12:28 p.m., the		investigating, reporting, resolu	-
	Social Worker indi	cated he had obtained the		and follow-up in a timely man	
		s on 4/4/11 and informed the		until the Council determines	nei
		vious) who was here at the		I	
		Vorker indicated he did not		bi-weekly meetings with SSD longer necessary.	are no
		statements were considered		The Facility Management Tear	:11
	abuse.		1	review all event reports, grieva	
	3 1 27(b)				-
	3.1-27(b)		1	and concerns daily during their	
			1	routine stand up meeting in or	
			1	investigate, resolve, and follow	1
			1	with any allegations of abuse i	
			1	or exploitation in a timely mar	iner.
			1		
			1		
			1	(d) How the corrective acti	· · · · I
			1	will be monitored to ensure the	
			1	practice will not recur, i.e., w	•
			1	quality assurance program w	rill be
			1	put into place:	
			1	The Administrator or designee	
			1	randomly interview 5 residents	• • • • • • • • • • • • • • • • • • •
				weekly x 4 weeks, then month	ly for 2
	1			additional months to determine	e if anv

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155458	B. WING		05/20/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 F	ADDRESS, CITY, STATE, ZIP CODE IFTH ST AND, IN46322	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	I	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
F0224 SS=A	The facility must d written policies and mistreatment, negrand misappropriate Based on record the facility failed resident was from the facility failed resident for about the investigation and the facility for the investigation and the facility failed resident reported the facility failed from the failed from	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. d review and interview, d to ensure each ee from neglect related of providing are for 1 of 4 residents buse. (Resident #13) is) e: on of an allegation of ident #13 was 19/11 at 10:32 a.m. on indicated the ed to the on-coming 0 p.m. to 10:00 p.m. is failed to perform	F0224	allegations of abuse neglect or exploitations have been made a reported promptly. The facility Risk manager will of these findings at the next mode (A/Risk Management meeting) such time substantial compliance been met and quarterly oversigned the RDCO is recommended who completing her system review whas a focus on A-N-E. (e) Date of compliance: 6/19 Preparation and/or execution of this planot constitute admission or agreement be provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-224 Staff Treatment of Resid (a) What corrective action(s) be accomplished for those reside found to have been affected by practice: Resident #13's allegations were reported to IDOH as required of 4/21/11 and Employee #4 and #4 have since been terminated — following their suspension and investigation. (b) How you will identify of residents having potential to be affected by the same practice what corrective action will be	report onthly until ce as ht by een which 2/11 In does by the or f e ents will dents the e n #5

000367

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLE	TED
		155458	B. WIN			05/20/20	11
		l	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		9630 FI			
HIGHLA	ND NURSING AND	REHABILITATION CENTER			AND, IN46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 '	te actions taken by the			taken:		
	facility included	d providing			Residents who are cognitively i		
	incontinence care to the resident and suspension of the two involved				were interviewed to determine		
					allegations of abuse/neglect had been reported to facility staff ar		
	CNA's. Staff in	nservicing was also			reported according to the facility		
	done related to the abuse policy.				standard and guidelines and not		
					were reported.		
	The facility oht	ained a statement from			•		
	1	on 4/22/11. The			(c) What measures will be p	ut	
					into place or what systematic		
	resident's statement indicated she				changes you will make to ensu		
	was in bed and needed to go the restroom and two girls came in and				that the practice does not recu		
					Staff were reeducated on abuse		
	1	n her brief and they			neglect and exploitation per fac standard and guidelines on 05/1	-	
	1	n it up. The resident			and 05/20/11.	.9/11	
	also indicated i	in the statement that			The Social Service Director or		
	this had happe	ned before and it was			Designee will meet bi-weekly	with	
	the same two	girls.			the Resident Council to ensure		
					allegations of abuse, neglect, ar	· .	
	The facility obt	ained statements from			exploitation are brought to the		
	1	One of the statements			Administrator and Risk Manage		
		esident reported that a			investigating, reporting, resolut		
		old her to go in her			and follow-up in a timely mann	er	
		statement indicated			until the Council determines		
	1 '	ported that two girls			bi-weekly meetings with SSD a longer necessary.	не по	
		•			The Facility Management Team	will	
		her to the bathroom			review all event reports, grievan		
	and they told h	er to go "pee" in bed.			and concerns daily during their		
					routine morning stand up meeti		
		ved on 5/19/11 at 12:20			order to investigate, resolve, an		
	1 '	tor of Nursing indicated			follow-up with any allegations		
	she was inform	ned of the above			abuse neglect or exploitation in	a	
	incident and in	itiated an investigation.			timely manner.		
	The two CNA's	were suspended at			(4) II d - d - d	-(-)	
	the time and di	d not return to work.			(d) How the corrective action		
	The allegation	of neglect of care was			will be monitored to ensure th practice will not recur, i.e., wh		
		pased on the resident's			quality assurance program wi		

Facility ID:

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COME - 05/20/	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 FI	ADDRESS, CITY, STATE, ZIP CO FTH ST AND, IN46322	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	and the intervie	reporting the incident ews of co-workers. The sing indicated CNA #4 ere terminated.		put into place: The Administrator or de randomly interview 5 re weekly x 4 weeks, then additional months to det allegations of abuse neg exploitations have been reported promptly. The facility Risk manag of these findings at the r QA/Risk Management n such time substantial cobeen met and quarterly of the RDCO is recommen completing her system r has a focus on A-N-E. (e) Date of compliance.	sidents monthly for 2 termine if any lect or made and er will report text monthly meeting until mpliance as oversight by ded when eview which	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE S COMPL 05/20/2	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9630	T ADDRESS, CITY, STATE, ZIP CODE FIFTH ST ILAND, IN46322	<u>. I</u>	
				11AND, 1140022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0225 SS=D	The facility must no have been found or mistreating resident have had a finding nurse aide registry mistreatment of resident of their property; a has of actions by a employee, which we service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including ir and misappropriat reported immediate the facility and to with State law through (including to the Sagency). The facility must halleged violations and must prevent the investigation is the results of all in reported to the addrepresentative and accordance with State survey and oworking days of the	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for a aide or other facility staff to de registry or licensing Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification ave evidence that all are thoroughly investigated, further potential abuse while in progress. Investigations must be ministrator or his designated it to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective				
	Based on record facility failed to abuse were investigated to investigated.	review and interview, the ensure allegations of stigated thoroughly gating an allegation of or 2 of 4 abuse allegations	F0225	Preparation and/or execution this plan does not constitute admission or agreement by provider of the truth of the facility alleged or conclusions set from the statement of deficient	the acts orth	06/19/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULT A. BUILDII B. WING		00	(X3) DATE: COMPL 05/20/2	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9	630 FIFT	DRESS, CITY, STATE, ZIP CODE FH ST ID, IN46322	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	reviewed and fa interview obtains investigation of a investigation. (R #32) (RN #1 and also failed to ensemble checks were obtained to employees review background check #1) Finding include: 1. The investigation abuse was review a.m. An allegating Resident #42 on investigation indereported to a nurrow was touched on a investigation reported to the investigation reported to the investigation reported to the investigation was noted to the investigation was of the investigation was of the investigation was allegation as the Mexican resident her at the Christing Hispanic resident total assist. The facility had not have the family of the the characteristic facility had not have the family of the the characteristic facility had not have the family of the characteristic facility had not have the family of the characteristic facility had not have the family of the characteristic facility had not have the characteristic facility had	iling to address an ed by a resident during an abuse for 1 of 4 abuse esidents #42, #19, and LPN #1). The facility cure criminal history ained as required for 1 of fewed for criminal eks. (Dietary Employee tion of an allegation of wed on 5/19/11 at 10:32 on of abuse was made by 12/7/10. The icated the resident sing assistant that she her breast. The ort indicated that no ional injuries or distress			This plan of correction is prepared and/or executed sobecause required. F-225 St. Treatment of Residents (a) corrective action(s) will be accomplished for those resident to have been affected the practice: Resident #42 nd longer resides in the facility. Resident #19's allegations or reported to IDOH as require 03/30/11 and RN #1 no long works at the facility Resident allegations of rough treatmed were reported to IDOH on 50 Dietary Employee #1 had a background check completed Indiana on 5/26/11 and the rewere placed in the employee. The Social Service Director reeducated on facility standard and guidelines for reporting abuse neglect and exploitation 5/19/11. The Administrator or reeducated on the requirem for obtaining background chon employees according to Indiana and facility standard 5/19/11. (b) How you will identify other residents har potential to be affected by same practice and what corrective action will be tal Residents who are cognitive intact were interviewed to determine if any allegations abuse had not been reporte according to facility, state, a federal requirements. Currel employee files were audited ensure background checks been completed appropriate	aff What dents by vere d on er t #32 nt /19/11 d for results e file. was and on on vas ents ecks s on ving the ken: ely of d nd nt to had	

000367

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLE	TED
		155458	B. WIN			05/20/20	11
			D. WIIV		DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	2		9630 FI			
HIGHLA	ND NURSING AND	REHABILITATION CENTER			AND, IN46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	things that are fu	inny and they were not			and filed in the employee red		
	concerned with the resident's statements.				(c) What measures will be		
	Preventative mea	asures taken by the			into place or what systemat	tic	
		ed as staff inserviced			changes you will make to		
	_ ·	se and the Administrator			ensure that the practice do not recur: Staff were reeduc		
	1				on abuse neglect and exploit		
		Nursing will follow up			per facility standard and		
		monitor and report			guidelines on 05/19/11 and		
	_	A (Quality Assurance)			05/20/11. The Social Service		
		report indicated the			Director or Designee will mee	et	
investigation was completed.					bi-weekly with the Resident	.	
					Council to ensure any allega of abuse, neglect, and or	tions	
	The closed record for Resident #42 was				exploitation are brought to th	_	
	reviewed on 5/19/11 at 10:50 a.m. The				Administrator and Risk Mana		
	resident was adn	nitted to the facility on			for investigating, reporting,	ĭ	
		sident's diagnoses			resolution, and follow-up in a		
	included, but we	•			timely manner until the Coun		
	1	h blood pressure, debility,			determines bi-weekly meetin with SSD are no longer	gs	
	1	ng surgery of the nervous			necessary. The Administrato	r or	
		7/10 hospital consultation			designee will review new		
	1 -	e resident had a history of			employee records to ensure		
		_			background checks have bee		
	,	enous) malformation and			completed and filed according		
	aneurysm with b	rain surgery.			Indiana and facility standards Facility Management Team w		
					review event reports, grievar		
		s' Notes were reviewed.			and concerns daily during the		
	1	n 12/7/10 at 12:00 p.m.,			routine morning stand up me	eting	
		ident reported that a man			in order to investigate, resolv		
	touched her brea	st a couple of days ago.			and follow-up with any allega		
	The writer and the	ne Administrator			of abuse neglect or exploitati a timely manner (d) How the		
	interviewed the	resident who concurred a			corrective action(s) will be	·	
	Hispanic man to	uched her breast and			monitored to ensure the		
	seems to think it				practice will not recur, i.e.,		
	Christmas Party.				what quality assurance		
					program will be put into pla		
	Social Service P	rogress Notes were			The Administrator or designe	e will	
	1 2001ai Soi vice i	0100011000011010					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155458	A. BUII B. WIN			05/20/20	011
HIGHLAI		REHABILITATION CENTER		9630 FI HIGHLA	DDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	indicated the resishe thinks a peer breast inappropricannot recall the also noted there residents in the fresidents were beindicated there will description. The facility was further document during the invest. When interviewed staff allegation and tu Worker indicated done with other Administrator (pthe time. When interviewed a.m., the Social indicated documentation interviews.	ed on 5/19/11 at 12:28 Worker indicated he had Emembers related to this rned them in. The Social d interviews were also residents and given to the revious Administrator) at ed on 5/20/11 at 11:44 Worker indicated he had			randomly interview 5 residen weekly x 4 weeks, then mont for 2 additional months to determine if any allegations of abuse neglect or exploitation have been made and reported promptly. The Administrator of designee will randomly reviewed monthly for 2 additional months to determine facility compliance with background checks on employees. The far Risk manager will report of the findings at the next monthly QA/Risk Management meeting until such time substantial compliance as been met and quarterly oversight by the RE is recommended when completing her system review which has a focus on A-N-E. (e) Date of compliance: 6/19/11	cility nese	
		a.m. The incident 1/11. The investigation					

PRINTED: 06/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL		
AND TEAN	or conduction	155458		LDING		05/20/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			9630 FI			
HIGHLAI	ND NURSING AND	REHABILITATION CENTER		1	ND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAU		loyee heard RN #1 state	+	IAG			DATE
	1	ou s pants all the					
	1	no one is stopping you."					
	· ·	ediate actions included					
	I -	RN and Physician and					
		on of the incident. No					
	· -						
	physical or emotional injuries/ distress noted.						
	The facility inves	stigation included					
	interviews obtained from other resident's.						
	The resident interviews were not obtained						
	until 4/4/11. Th	e Social Worker obtained					
	interviews from	four other residents. One					
	of the interviews	indicated Resident #32					
	was asked if she	had any experiences					
	where staff had b	een mean to her. The					
	resident stated L1	PN #1 can be mean some					
		s no follow up related to					
		ent obtained during the					
	investigation.						
	The record for R	esident #19 was reviewed					
		3 p.m. The resident's					
		ed, but were not limited					
	ı ~	tia, osteoarthritis, and					
	severe dysphagia	(a swallowing disorder).					
	The 5/4/11 Minir	num Data Set (MDS)					
	quarterly assessn	nent indicated the					
	resident had shor	t and long term memory					
	1 ^	s difficulty with making					
	decisions in new	situations. The					
	assessment also i	ndicated the resident					
	required total ass	istance with personal					

000367

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE (COMPL 05/20/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER	!!			DDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER			ND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	hygiene.						
	on 5/20/11 at 9:4 diagnoses includ to, anemia, high cerebral vascular 2/16/11 Minimum quarterly assessment resident scored a interview for me indicates the resimpaired. When interviewed p.m., the Director RN was suspend came in the next The Director of the Resident #32 that her. The Director this was an alleger.	esident #32 was reviewed e1 a.m. The resident's ed, but were not limited blood pressure, and accident (stroke). The m Data Set (MDS) ment indicated the (15) on a BIMS (brief intal status), a score of 15 dent is not cognitively ed on 5/19/11 at 12:20 or of Nursing indicated the ed at the time and the RN morning and resigned. Nursing indicated she was allegations made by t LPN #1 was mean to or of Nursing indicated ation of abuse.					
	p.m., the Social obtained the resi	Worker indicated he had dent interviews on 4/4/11					
	who was here at Worker indicated	e Administrator (previous) the time. The Social I he did not feel Resident					
		was abuse because there tween the two and the sanxious.					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	(X2) MULTIPLE CO A. BUILDING B. WING	00	ì í	e survey Pleted /2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A 9630 FI	ADDRESS, CITY, STATE, ZIP OF THE STAND, IN46322	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	p.m., the Director allegation made reviewed with the and LPN #1 was The Director of I investigation of I investigation of the director of I investigation o	ed on 5/19/11 at 2:00 or of Nursing indicated the by Resident #32 was e facility Administrator suspended at this time. Nursing indicated an the allegation of abuse ove was now being				
	reviewed on 5/20 Employee #1 wa criminal backgro from a county in criminal backgro obtained from th When interviewed a.m., the facility	mployee records were 0/11 at 9:00 a.m. Dietary is hired on 3/28/11. A bund check was obtained the state of Illinois. A bund check was not it is estate of Indiana. Ed on 5/20/11 at 10:50 Administrator indicated check was obtained from indiana.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155458	B. WIN	G		05/20/2	011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		9630 FI	.DDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN46322		
HIGHLAN (X4) ID PREFIX TAG F0226 SS=D	SUMMARY S (EACH DEFICIENT REGULATORY OR The facility must d written policies and mistreatment, neg and misappropriat Based on recor the facility failed policy related to allegations of a allegations of a completing crim background che employees who reviewed. (Res #19) (Dietary Employ Findings includ	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. d review and interview, d to follow their abuse o investigating buse for 2 of 4 buse reviewed and hinal history ecks for 1 of 5 ose files were idents #42, #32, and yee #1) e: cy titled "Investigation	F0	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Preparation and/or execution of this plar not constitute admission or agreement by provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-226 Practice and Guidelines regarding Abuse (a) What corrective action(s) be accomplished for those resid found to have been affected by the practice: Resident #42 has been discharge from the facility. Resident #19's allegations were	will ents	(X5) COMPLETION DATE 06/19/2011
	Federal or State on 5/17/11 ay 1 of Nursing provindicated the popular policy was issurevised on 3/11 all alleged violatistreatment, reserving to be reported administrator/Expolicy indicated investigate each thoroughly and the Administrator.	eged violations of the Laws" was reviewed the Laws" was reviewed the Laws reviewed the policy and tolicy was current. The the don 10/04 and last the policy indicated the policy and th			reported to IDOH as required of 3/30/11 and RN #1 no longer wat the facility Resident #32 allegations of roughtreatment were reported to IDOS 5/19/11 Dietary Employee #1 had a background check completed for Indiana on 5/26/11 and the result were placed in the employee file. The Social Service Director was reeducated on facility standard a guidelines for reporting abuse neglect and exploitation on 5/19 (b) How you will identify off residents having potential to be affected by the same practice a what corrective action will be	orks gh H on or lts e. s and 0/11.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155458	B. WIN			05/20/20	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ł.		1	FTH ST		
HIGHI AI	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
				L	1140, 11440022		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	· · · · · · · · · · · · · · · · · · ·		DATE
	to be placed or				taken:		
		nding the results of the			Residents who are cognitively i were interviewed to determine i		
	investigation. In	nvestigation steps were			allegations of abuse had not bee		
	to include inter	view of employee,			reported according to facility, st		
	visitors, or resid	dents who may have			and federal requirements.	,	
	knowledge of the	he incident. Written			Current employee files were au	dited	
		was to be kept of each			to ensure background checks ha		
		. The policy also			been completed appropriately a	nd	
		ral law requires the			filed in the employee record.		
		evidence of the					
	investigations				(c) What measures will be p	ut	
	•	neglect, abuse, injuries			into place or what systematic changes you will make to ensu	mo	
		•			that the practice does not recu		
	of unknown so				Staff were reeducated on abuse	••	
	misappropriation	on of property.			neglect and exploitation per fac	ility	
					standard and guidelines on 05/1		
		cy titled "Abuse,			and 05/20/11.		
	Neglect, and E	xploitation" was	The Administrator was reeducated on				
	received from t	he Director of Nursing			the requirements for obtaining		
	on 5/19/11 at 1	0:00 a.m. The Director			background checks on employe		
	of Nursing indic	cated the policy was			according to Indiana and facility	у	
	current. The p	olicy was issued on			policy on 05/19/11.		
	11/04. The pol	icy indicated criminal			The Social Service Director or Designee will meet bi-weekly	with	
	1	ecks were to required			the Resident Council to ensure		
		ng of new employees.			allegations of abuse, neglect, an	-	
		cated the facility was to			exploitation are brought to the		
	conduct their o	_			Administrator and Risk Manage	er for	
					investigating, reporting, resoluti		
	_	See Investigation			and follow-up in a timely mann	er	
		eged Violation of			until the Council determines		
	Federal and/or	State Laws.			bi-weekly meetings with SSD a	re no	
					longer necessary. The Administrator or designee v	,, ₁₁₁	
		on of an allegation of ed on 5/19/11 at 10:32 a.m.			review new employee records to		
		ed on 5/19/11 at 10:32 a.m. buse was made by			ensure background checks have		
	. •	2/7/10. The investigation			completed and filed according t		
		dent reported to a nursing			Indiana and facility standards	-	
		was touched on her	\perp				
			_				

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPI	LETED
		155458	B. WIN			05/20/2	2011
		l .	P. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			FTH ST		
нісні лі	ND NI IDSING AND	REHABILITATION CENTER			AND, IN46322		
HIGHLA	ND NORSING AND	REHABILITATION CENTER		HIGHLA			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		tigation report indicated			The Facility Management Tea		
	that no physical o	r emotional injuries or			review event reports, grievanc	es, and	
	distress was note	d to the resident. The			concerns daily during the Mor	ıday	
		ort indicated that an			through Friday stand up meeti	ng in	
	_	initiated and the results of			order to investigate, resolve, a	nd	
	the investigation of	did not support the			follow-up with any allegations	of	
	allegation, as the	resident reported a			abuse neglect or exploitation i	n a	
		wheeled himself over to			timely manner		
		as party. Both of the					
		s in the facility required			(d) How the corrective acti	on(s)	
		report also indicated the			will be monitored to ensure t	he	
	I -	d a Christmas party yet.			practice will not recur, i.e., w	hat	
	The family of the resident was contacted and they said the resident will repeat things that				quality assurance program w	ill be	
					put into place:		
		y were not concerned with			The Administrator/designee w	ill	
		ements. Preventative			randomly interview 5 resident	S	
	1	y the facility were listed as			weekly x 4 weeks, then month	ly for 2	
		outinely on abuse and the			additional months to determin	-	
		Director of Nursing will			allegations of abuse neglect or	-	
		tinue to monitor and report			exploitations (A-N-E) have be		
	committee. The re	(Quality Assurance)			made and that they have been		
	investigation was				reported promptly.		
	investigation was	completed.			The Administrator/designee w	ill	
	The closed record	I for resident #42 was			randomly review 5 employee		
		11 at 10:50 a.m. The			weekly x 4 weeks, then month		
		itted to the facility on			additional months to determin	-	
		lent's diagnoses included,			facility compliance with backs		
		ed to, convulsions, high			checks on employees.	-	
		ebility, aftercare following			The facility Risk manager will	report	
	· ·	vous system. A 10/27/10			of these findings at the next m	~	
		tion note indicated the			QA/Risk Management meetin		
	resident had a his				such time substantial complian	_	
		nalformation and aneurysm			been met and quarterly oversign		
	with brain surgery				the RDCO is recommended w		
					completing her system review		
	The 12/10 Nurses'	Notes were reviewed. An			has a focus on A-N-E.		
		7/10 at 12:00 p.m.,					
		dent reported that a man			(e) Date of compliance: 6/1	9/11	
	touched her breas	st a couple of days ago.					
		Administrator interviewed					
	the resident who	concurred a Hispanic man					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		10	00	COMPL	ETED
		155458	A. BUILDI	NG		05/20/2	011
			B. WING	TDEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
LUCLUA	ND NILIDOING AND	DELIABILITATION CENTED			FTH ST		
HIGHLAI	ND NURSING AND	REHABILITATION CENTER		IIGHLA	ND, IN46322		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
	touched her breas	st and seems to think it		I			
	happened at the (Christmas Party.					
		ogress Notes were					
		y made on 12/8/10 indicated					
		med staff that she thinks a					
		ouched her breast nd the resident cannot					
		ate. The entry also noted					
		wo Hispanic residents in the					
	1	of the residents were bed					
	bound. The note	also indicated there were					
	no visitors that fit	the description.					
		nable to provide any further					
		f the actions taken during					
	the investigation.						
	When interviewed	d on 5/19/11 at 12:28 p.m.,					
	the Social Worker	•					
		members related to this					
	allegation and tur	ned them in. The Social					
	Worker indicated	interviews were also done					
	with other resider	nts and given to the					
	Administrator (pr	evious Administrator) at the					
	time.						
	Whom internion	l on E/20/44 of 44:44 o					
		d on 5/20/11 at 11:44 a.m., r indicated he had no					
	l mo occiai monici	the above interviews.					
	2. The investigat	ion of an allegation of					
	abuse for Resider	nt #19 was reviewed on					
		m. The incident occurred					
		nvestigation indicated an					
		RN #1 state to the resident					
		all the time so go ahead no					
		ou." The facility's					
		s included suspension of					
	-	ician and family notification					
	or the inclaent. N	lo physical or emotional	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIM DDIG	00	COMPLETED	
		155458	A. BUILDING		05/20/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R	I			
LUCLUA	ND NILIDOING AND	DELIABILITATION CENTED		FIFTH ST		
HIGHLAI	ND NURSING AND	REHABILITATION CENTER	HIGHI	_AND, IN46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	injuries/ distress	noted.				
		tigation included interviews				
		ner resident's. The resident				
		ot obtained until 4/4/11.				
		r obtained interviews from nts. One of the interviews				
		nt #32 was asked if she had				
		where staff had been mean				
		ent stated LPN #1 can be				
		s. There was no follow up				
		ve statement obtained				
	during the investi	gation.				
		sident #19 was reviewed on				
	5/19/11 at 1:13 p.r					
	_	ed, but were not limited to,				
		osteoarthritis, and severe				
		llowing disorder). The				
		eata Set (MDS) quarterly				
		ated the resident had short				
	_	mory problems and has king decisions in new				
	-	ssessment also indicated				
		ired total assistance with				
	personal hygiene					
	"					
	The record for Re	sident #32 was reviewed on				
	5/20/11 at 9:41 a.n					
	•	ed, but were not limited to,				
	, ,	od pressure, and cerebral				
		t (stroke). The 2/16/11				
	Minimum Data Se	eated the resident scored a				
		rief interview for mental				
	1 ' '	f 15 indicates the resident				
	is not cognitively					
	When interviewed	l on 5/19/11 at 12:20 p.m.,				
		rsing indicated the RN was				
	suspended at the	time and the RN came in				
	the next morning	and resigned. The Director				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 05/20/2	ETED	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		9630 FII	DDRESS, CITY, STATE, ZIP CODE FTH ST ND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	the allegations ma LPN #1 was mean	ed she was not aware of ade by Resident #32 that to her. The Director of this was an allegation of					
	the Social Worker the resident interv informed the Adm was here at the tir indicated he did n statement was abo	on 5/19/11 at 12:28 p.m., indicated he had obtained riews on 4/4/11 and inistrator (previous) who ne. The Social Worker ot feel Resident #32's use because there was a ne two and the resident					
	Director of Nursin made by Resident facility Administra suspended at this	on 5/19/11 at 2:00 p.m., the g indicated the allegation #32 was reviewed with the tor and LPN #1 was time. The Director of an investigation of the e was now being					
	reviewed on 5/20/ Employee #1 was background check county in the state	ployee records were 11 at 9:00 a.m. Dietary hired on 3/28/11. A criminal was obtained from a of Illinois. A criminal was not obtained from the					
	the facility Adminis	on 5/20/11 at 10:50 a.m., strator indicated the was obtained from Illinois					
	3.1-28(a)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155458 05/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9630 FIFTH ST HIGHLAND NURSING AND REHABILITATION CENTER HIGHLAND, IN46322 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0247 A resident has the right to receive notice before the resident's room or roommate in the SS=D facility is changed. Based on record review and interview, the 06/19/2011 F0247 Preparation and/or execution of facility failed to ensure notice of room change this plan does not constitute was provided prior to the change for 2 of 3 admission or agreement by the residents who met the criteria for room provider of the truth of the facts transfers. (Residents #28 & #36) alleged or conclusions set forth on the statement of deficiencies. This Findings include: plan of correction is prepared and/or executed solely because The policy titled, "Room Change/Roommate required. Assignment" was reviewed on 5/18/11 at 5:06 p.m. The policy was received from the Administrator at this time. The Administrator F 247 Notification of Roommate indicated the policy was current. Change The policy indicated "It will be the standard of (A)What corrective actions will be the facility to honor the resident's right to receive notice before the resident's room or roommate accomplished for those residents in the facility is changed." The policy also found to have been affected by the indicated if a resident is being moved at the practice? facility's request, a staff member was to explain Issue # 1 and # 2 were identified the reason for the move and provide the after the fact – because of this staff resident with the opportunity to view the new offered an apology and explanation location, meet the new roommate, and ask to Resident's # 28 and # 38 as to why questions about the move. Documentation was room changes where made (initial to be made in the resident's medical record. based on Isolation needs) and secondary based on (removal from 1. When interviewed on 5/16/11 at 12:46 p.m., Resident #28 indicated she had a room change Isolation needs).. in the last nine months. The resident indicated she was sent to the hospital and when she (b) How other residents having returned she required isolation and was placed the potential to be affected by the in another room for about two weeks, The same practice will be identified resident indicated after the isolation was over and what corrective actions will be she was moved to another room and was told of taken? the room change on the day she was moved. Facility audit was conducted of She was not notified which roommate she was active residents to identify any room going to have. changes over that last 30 days to ensure that the appropriate The record for Resident #28 was reviewed on notification process was being 5/17/11 at 2:07 p.m. The resident's diagnoses

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155458 05/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9630 FIFTH ST HIGHLAND NURSING AND REHABILITATION CENTER HIGHLAND, IN46322 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE included, but were not limited to, hemiplegia and followed. Any issues identified were muscle weakness. The resident was first addressed and/or corrected. admitted to the facility on 11/26/10. The resident was sent to the hospital on 3/28/11 and (c) What measures will be put into was readmitted to the facility on 4/5/11. The place or what systemic changes resident was readmitted to room 1-B. will be made to ensure that the practice does not recur? A physician's order was written on 4/18/11 to move the resident to room 12-B. An entry in the Nursing Staff\ Social Services were 4/2011 Nurses' Notes was made on 4/18/11 at re-educated on the components of F 1:45 p.m. This entry indicated the resident was 247 and the need to ensure that the moved to room 12-B. There was no documentation of the resident being notified resident and family receive notice prior to the room change or of the resident being before the resident receives a room given the opportunity to meet her new roommate change or a new roommate. Any prior to the move. potential room changes or roommate changes will be reviewed with Social The last entry in the 4/11 Social Service Service, DNS and Administrator to Progress Notes was made on 4/4/11. This entry ensure appropriate notification and indicated the resident was readmitted back the documentation has occurred prior to facility. There were no entries related to the change, this will also include resident's 4/18/11 room change. documentation in the nurse's notes along with the required MD order. When interviewed on 5/19/11 at 10:15 a.m., the Review of form FGS 1602 facility Administrator indicated the resident Notification of Room or Roommate should have been informed of the room change and should have been involved in the room Change was reviewed with the Social change. Services Director for appropriate use to be used prior to an actual room and/or roommate change along with 2. When interviewed on 5/16/11 at 1:19 p.m., the required f/u documentation. Resident #36 indicated she had had a room or room mate change in the last nine months. The (d) How will the corrective actions resident indicated she was moved to another be monitored to ensure the room and was not given notice beforehand. practice will not recur and what quality assurance program will be The record for Resident #36 was reviewed on put into place? 5/18/11 at 2:30 p.m. The resident was transferred to room 1-B on 4/18/11 for isolation. Admin\DNS\SSD will review the 24 The resident was transferred to room 7-C on hour report at each morning stand-up 5/9/11. meeting for the next 4 weeks, making The 5/2011 Nurses' Notes were reviewed. note of any room changes and review There was no documentation in the 5/9/11 of the clinical record for accurate

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		1				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155458	B. WINC			05/20/2	011
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NAME OF F	PROVIDER OR SUPPLIER			9630 FIF	TH ST		
		REHABILITATION CENTER		HIGHLA	ND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	change. There was 5/7/11 or 5/8/11 Nu resident being notifichange. There we made during 5/201 When interviewed of facility Administrates should have been it	ted to the resident's room is no documentation in the irses' Notes related to the iried prior to the room ere no Social Service Notes 1. on 5/19/11 at 10:15 a.m., the or indicated the resident informed of the room change eren involved in the room			notification\documentation of resident and family\ responsible party. Identification of any discrepancy will result in an immediate follow up call to family/responsible party as well resident interview to ensure contentment with current room and/or roommate. Upon completion of the above - Social Service will complete an weekly (for the following two months) on any room and/or roommate changes to ensure tim notification was given to parties involved based on facility form 1602. Results of these findings will be presented at the monthly Risk Management \Quality Assurance meeting to determine if complia has been met and quarterly over by the RDCO is recommended when the completes her system review which includes room changes. (e) Date of Correction: 6/19/11	as a audit nely FGS e nce sight when vs	
F0250 SS=E	social services to a highest practicable psychosocial well- Based on recor	rovide medically-related attain or maintain the e physical, mental, and being of each resident. The review and interview, and to ensure 3 of 5 were receiving	F02	250	Preparation and/or execution of this plan not constitute admission or agreement by provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is	the or	06/19/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	I I			(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		ETED		
		155458	B. WIN			05/20/20)11
			-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	ę.		9630 FII	FTH ST		
HIGHLA	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	anti-anxiety me	edications in the			prepared and/or executed solely because required.		
	sample of 25 w	ere receiving behavior			required.		
	monitoring. The	e facility also failed to			F-250 Social Services		
	ensure medica	lly related social					
	services were	provided to 1 resident			(a) What corrective action(s)		
	1	of 25 related to the use			be accomplished for those resid		
	1	essant. (Residents #8,			found to have been affected by practice:	uie	
	#11, #27 and #	•			Residents # 11, 35, 27, and 8 w	ere	
	,				reassessed by psychological ser		
	Findings includ	le:			and the interdisciplinary team/S		
	i indings includ	ic.			ensure each resident has been		
	1 The record	for Docidont #11 was			properly assessed, appropriate		
		for Resident #11 was			medications ordered and/or		
		17/11 at 12:35 p.m.			tapered/discontinued, care plant		
	1	diagnoses included,			with interventions that meet the		
	1	nited to, Alzheimer's			needs of the particular behavior		
	dementia and	Obsessive Compulsive			documentation by the nursing a social services department to re		
	Behaviors.				the current residents behaviors,		
					of care, and follow-up.	Piulis	
	An entry in the	Physician progress			The Pharmacy consultant will r	eview	
	notes, dated 1/	/10/11, indicated the			resident medications for approp	riate	
	resident had be	een digging in the anal			diagnosis and dosage to provide	e the	
	area and touch	ing all other parts			optimum results.		
	including her c	onjunctiva (area of the			The Social Service Director,		
	1	leveloped chronic			Licensed Nurses and Interdisciplinary Care Plan team	,	
	recurrent conju	•			were re-educated on the facility		
					standards regarding assessment		
	Documentation	n in the Nurses' notes			management of behavior issues		
		p.m., indicated "Seen			the need for appropriate		
		bowel movement) on			documentation and follow-up u	ntil	
	,	oserved scratching			resolved.		
	1	_					
	eyes with finge	illall.			(b) How you will identify of		
	A Discussion				residents having potential to b		
	1 *	order, dated 1/24/11,			affected by the same practice a what corrective action will be	and	
		esident was to receive			taken:		
	Ativan (an anti-	-anxiety medication)			taken.		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155458	B. WIN			05/20/20	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .		9630 FI			
	ND NITIDGING AND	REHABILITATION CENTER			AND, IN46322		
ПІВПІАІ	ND NORSING AND	REHABILITATION CENTER		HIGHLA	AND, 11140322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	0.5 milligrams	(mg) by mouth every			Residents who presently exhibit	t or	
	morning.				have exhibited		
					psychological/behavior issues in		
	An entry in the	Physician progress			last 30 days were reassessed by	the	
	1	24/11, indicated "DON			SSD/interdisciplinary team to		
	· ·	·			determine if appropriate		
		atient is always			interventions had been impleme		
		es after touching the			care planned, and documented i medical record.	in the	
	anal area. War	ited to start her on			medical record.		
	some meds to	calm her down as per			(c) What measures will be p		
	family request.	"			(c) What measures will be p into place or what systematic	ut	
					changes you will make to ensu	re	
	The Behavior N	Management Book was			that the practice does not recu		
		18/11 at 1:00 p.m.,			The Social Service Director,		
		heet for the resident in			Licensed Nurses and		
		neet for the resident in			Interdisciplinary Care Plan tean	n	
	the book.				were re-educated on the facility	,	
					standards regarding assessment	and	
	Interview with t	he Social Service			management of behavior issues	and	
	Director on 5/1	9/11 at 1:30 p.m.,			the need for appropriate		
	indicated the re	esident did not have a			documentation and follow-up u	ntil	
	sheet in the be	havior monitoring book			resolved.		
		not been notified of			The facility employees were		
		rs. He further indicated			reeducated on the facility stands		
		nad been having			for notification of behaviors to		
		•			licensed staff and social service	·s	
		vas to be notified and a			department. The Social Service Director or		
		initiated and kept in			designee will review new admis	ssions	
	the behavior m	onitoring book for a			readmissions, or change of statu		
	year.				residents to determine if the res		
					psychological/behavior concern		
					have been assessed, care planne		
					documented according to facilit		
					standards		
					The Facility Management Team	will	
					review any residents who are		
					displaying any new or escalatin	-	
					psychological/behaviors during	the	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	00 	COMPLETED
		155458	B. WING		05/20/2011
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 F	ADDRESS, CITY, STATE, ZIP CODE IFTH ST AND, IN46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				Monday through Friday stand meeting in order to investigate formulate a plan of care, resolv follow-up with any concerns in timely manner.	e, /e, or
	reviewed on 5/2 The resident's of but were not line schizophrenia,	for Resident #35 was 17/11 at 12:10 p.m. diagnoses included, nited to, depression, and anxiety. The dmitted to the facility		(d) How the corrective acti will be monitored to ensure the practice will not recur, i.e., we quality assurance program we put into place: The Director of Social Service designee will review 5 records randomly each week weekly xeeks, then monthly for 2 add months to determine if the resi psychological/behavior concer have been properly assessed if needed by Psychological Servidocumentation of behaviors is current and with appropriate picare. The Facility Risk Manager will report results at the next QA/R Management meeting and morthereafter until substantial compliance has been achieved then quarterly monitoring to memory compliance (e) Date of compliance: 6/1	hat hat ill be s or 4 itional dents ns ces, an of l isk hthly and aintain

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE COMPL		
		155458	A. BUI B. WIN	LDING IG		05/20/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		1	FTH ST AND, IN46322		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Review of Social Service progress		İ				
l	notes, dated 2/ resident had a	17/11, indicated the					
		out has not displayed					
		in a long time and has					
		he resident was able to eeds and denied any					
	symptoms of de						
	The last o	documented					
	Social Se						
	Progress	Notes was					
	on 3/11/1	1 which					
	indicated	the resident					
	had a his	tory of falls,					
	and had i	no signs of					
	depression	on or					
	behaviors	s exhibited					
	since her	admission.					
	Notes, dated 4/ nursing reporte of her nose and	Psychiatrist Progress /25/11, indicated d she "blows snot" out d smears feces after ds in her pants.					
		quarterly Minimum Data					
	I VENIEW OF THE C	quarterry wiiriiirium Data					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	` ′	TE SURVEY MPLETED	
THEFTERN	or condition	155458	- 1	LDING		1	0/2011
			B. WIN		DDRESS, CITY, STATE, ZIP CO		
NAME OF I	PROVIDER OR SUPPLIER			9630 FII			
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION) essment dated 4/20/11		TAG	DEFICIENCY)		DATE
	1 ' '	esident was able to be					
		derstands, there were					
	no behaviors no	·					
		no delirium noted.					
	,						
	Review of the 4	1/8/11 current plan of					
		cated the behavior					
	l •	y inappropriate as					
	•	ontaminates hands					
		smears stool, spits					
		m. The nursing					
		ere to lay the resident als, report to physician					
		e-approach resident					
		orce positive behavior.					
	later, and remie	orde positive benavior.					
	Review of the E	Behavior Monitoring					
	Record indicate	ed symptoms:					
	psychotic symp	otoms, and					
		Approaches: enjoys					
	1	talk about her family, 1					
		on. medications ativan					
	1 `	medication) and					
	thiothixene (an						
	1 '	urther review of the oring Record indicated					
		documented behaviors					
		t were in the book for					
		April or May 2011.					
	Nurse's Notes	dated 4/8/11 at 2:15					
	I	resident was awake					
	· ·	ide of bed yelling for					
	toilet paper. Th	ne resident had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155458		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/20/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	FTH ST		
HIGHLA	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG	<u> </u>	I movement all over	+	TAG	DLI ICILICI I		DATE
	bed and clothe						
	Nurse's Notes,	dated 4/8/11 at 9:30					
	a.m., indicated	the resident noted to					
	have smeared	bowel movement all					
		o and pants and					
	wheelchair.						
	Nursa's Notes	dated 4/9/11 at 1:15					
	·	the resident was					
	throwing fecal						
		matter on noor.					
	Nurse's Notes,	dated 4/9/11 8:45					
	p.m., indicated	the resident pulled					
	down her pants	s and removed fecal					
	matter from he	r private area.					
	Review of the I	Behavior Monitoring					
		ted none of those					
		e documented in the					
	book or addres	sed in the behavior					
	monitoring reco	ord.					
],,						
		the Social Service					
		7/11 at 3:00 p.m., ne "dropped the ball"					
		's behavior of smearing					
		erself and other items.					
		at he did not place the					
		in the behavior plan or					
		e further indicated that					
		ive any referral forms					
		aff regarding the feces					
	_	was also unaware of					

000367

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPLI		
		155458	A. BUI B. WIN	LDING IG		05/20/20	011
NAME OF P	PROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		1	FTH ST AND, IN46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE	COMPLETION DATE
		egarding the feces					
	smearing behav	vior.					
	Interview with L	.PN #4 on 5/17/11 at					
	=	cated the resident has					
		being "a digger;" she s and smears it on					
	_	N indicated that she					
		o this on her shift. The					
		the behaviors. The					
		the resident still has					
		s behavior about a					
	week ago.						
		he Director of Nursing					
		:30 a.m., indicated her om the nursing staff					
	•	te a behavior form and					
	give it to social						
	behavior log co	uld be updated.					
	3. The record for						
		1 at 10:25 a.m. The ses include, but were not					
	_	sion, anxiety, and altered					
	Review of	Social Service					
	•	notes dated					
		10, and 12/10					
	indicated t	he resident					
	with no be	haviors but					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE : COMPL		
		155458	B. WIN			05/20/2	011
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		1	FTH ST AND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	yells out "l	Hey" with					
	periods of disorientation.						
	Review of	the significant					
	change M	•					
	assessme	nt dated 3/11					
	indicated t	he resident					
	was usual	ly understood					
	and usuall	y understands,					
	has halluc	inations, has					
	delusions,	physical,					
	verbal, an	d other					
	behaviora	l symptoms					
	directed to	ward others					
	and not di	rected toward					
	others, int	rudes on the					
	privacy or	activity of					
	others, an	d disrupts care					
	or living er	nvironment.					
		the current 3/3/11 plan of					
		avior problem grabs others t people, constant yelling r/t					
		cognitive impairment, family /chiatrist to see resident.					

IDENTIFICATION NUMBER: 155458	A. BUILDING	00	COMPLETED
155458			
1	B. WING		05/20/2011
NAME OF PROVIDER OR SUPPLIER		ADDRESS CITY STATE ZIP CODE	
R			
REHABILITATION CENTER			
		PROVIDER'S PLAN OF CORRECTION	(X5)
		CROSS-REFERENCED TO THE APPROPRIATION	
·	TAG	DEFICIENCY)	DATE
navioral changes, explain to ce, reinforce positive ster medications,			
dent had symptoms of g out socially inappropriate, mptoms. The first avior in the record was dated cated 12 p.m. and 4 p.m. g out 1 to 3 hours, iroaches 1 to 1, lay down for roach later. S Notes dated 5/7/11 8:30 sident yelling out hey hey as an (antianxiety medication) view of Nurse's Notes dated the resident was screaming in pain said yes gave pain 15 p.m., resident continues van given. Jian orders dated 1/12/11 coam (an antianxiety ligram (mg). one tablet three forn for agitation. Medication Administration dicated the resident received m on 3/2 at 3:30 a.m., 3/5/11 in 11:30 a.m., and on c.m. MAR indicated the resident received m on 4/1/11 at 2:00 p.m., 4/20 at 6:00 p.m.,			
O THE HOUSE WINDS HIS TOURS HE TOURS HE TOURS	REHABILITATION CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) Toaches were to report to havioral changes, explain to nce, reinforce positive ster medications, dent later, and intervene as Phavior Monitoring Record ident had symptoms of g out socially inappropriate, mptoms. The first avior in the record was dated cated 12 p.m. and 4 p.m. g out 1 to 3 hours, proaches 1 to 1, lay down for proach later. Is Notes dated 5/7/11 8:30 resident yelling out hey hey as van (antianxiety medication) review of Nurse's Notes dated the resident was screaming in pain said yes gave pain r 15 p.m., resident continues van given. Stan orders dated 1/12/11 pam (an antianxiety lligram (mg). one tablet three prn for agitation. 11 Medication Administration dicated the resident received am on 3/2 at 3:30 a.m., 3/5/11 5/11 at 11:30 a.m., and on p.m. 11 MAR indicated the resident razepam on 4/1/11 at 2:00 0 p.m., 4/20 at 6:00 p.m., n., and 4/28/11 at 6:30 p.m.	DREHABILITATION CENTER DREHABILITATION CENTER DREHABILITATION CENTER ID PREFIX RLSC IDENTIFYING INFORMATION) Toaches were to report to havioral changes, explain to nee, reinforce positive ster medications, dent later, and intervene as Phavior Monitoring Record ident had symptoms of g out socially inappropriate, mptoms. The first avior in the record was dated cated 12 p.m. and 4 p.m. g out 1 to 3 hours, proaches 1 to 1, lay down for proach later. So Notes dated 5/7/11 8:30 esident yelling out hey hey as aren (antianxiety medication) eview of Nurse's Notes dated the resident was screaming in pain said yes gave pain in pain said	D REHABILITATION CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) To aches were to report to havioral changes, explain to nee, reinforce positive ster medications, dent later, and intervene as Phavior Monitoring Record ident had symptoms of go ut socially inappropriate, mptoms. The first avior in the record was dated cated 12 p.m. and 4 p.m. go ut 1 to 3 hours, proaches 1 to 1, lay down for proach later. S Notes dated 5/7/11 8:30 esident yelling out hey hey as ran (antianxiety medication) eview of Nurs's Notes dated the resident was screaming in pain said yes gave pain 115 p.m., resident continues van given. Sian orders dated 1/12/11 pam (an antianxiety liligram (mg). one tablet three pm for agitation. 11 Medication Administration dicated the resident received im on 3/2 at 3:30 a.m., 3/5/11 5/11 at 11:30 a.m., and on p.m. 11 MAR indicated the resident tazepam on 4/1/11 at 2:00 2 p.m., 4/20 at 6:00 p.m.,

PRINTED: 06/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/20/2	ETED	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R			FTH ST		
HIGHLAI	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		N #2 on 5/17/11 at 12:55		IAG			DATE
	p.m. indicated the resident was not on a						
	behavior monitoring plan currently and has						
		viors in the past couple of ecline. The LPN indicated					
		displays a behavior or they					
		ne prn ativan they were					
		It a new or worsening					
	mailbox.	I place it in Social Service					
	Interview with the	Social Service Director on					
		m., indicated that he has not					
		r referrals from nursing					
	•	dent's behavior and ativan. He indicated that he					
	should have recei	ved information regarding					
		ving the prn ativan. The					
		ector indicated a behavior plan for one year regardless					
	· ·	s still displaying it. Further					
		d the only documented					
		ehavior monitoring book 6/11 and there had been					
	none prior to that						
	Interview on 5/17/	11 at 3:55 p.m., with LPN #4					
		11 shift indicated the resident					
	usually yells outlo	ud constantly and all the					
		ed that she has had to give					
	occasions after sh	rn ativan on several ne had tried 1 to 1					
		other interventions before					
		medication. She indicated					
		completed a referral form If to give the resident the prn					
		it in social service mailbox.					
	Interview with the	Director of Nursing on					
	5/19/11 at 9:30 a.m., indicated her						
		the nursing staff were to ior form when the resident					
	complete a penav	ioi ioitti wileti tile lesidetit					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLE		
AND PLAN	OF CORRECTION	155458	1	LDING	00	05/20/20	
		100400	B. WIN		DDDDGG GITH GTATE ZID GODE	00/20/20	''
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE FTH ST		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	with social service	they can communicate that .					
	4. The record for	or resident #8 was					
	reviewed on 5/	17/11 at 2:10 p.m. The					
	resident had dia	agnoses that included,					
	but were not lin	nited to, cerebral palsy					
	with mental reta	ardation, and					
	depression.						
	Review of the N	May 2011 medication					
		record indicated the					
	resident was cu	irrently receiving					
	Remeron (an a						
	,	mg (milligram) daily.					
	ŕ						
		progress notes were					
		resident was seen by a					
		7/27/10. The progress					
	note dated 7/27	·					
	1 *	nsult. Requested to					
		atient) due to her					
		tive" statement. Pt.					
		e a statement about					
	1	ther and scored a 4 on					
	the geriatric de	•					
		e Social Worker, 5					
		e is depressed					
		ecently restarted on					
		etite and depression -					
		ysician) note 7/13/10					
		epressed. Pt. denies					
	feeling depress						
		e increased to 30 mg					
	,	sleep) on tomorrow."					
	The psychiatris	t continued to see the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUI	LDING	NSTRUCTION 00 ———	(X3) DATE (COMPL 05/20/2	ETED	
		100400	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF I	PROVIDER OR SUPPLIER	2		9630 FII			
		REHABILITATION CENTER		1	AND, IN46322		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	+	lly. The progress note,		1710			DATE
	dated 2/22/11,						
	· ·	licated, "She is now off					
	1 ' '	roblems are reported					
		(discontinuation) of the					
		will sign off at this					
	time."	· ·					
	Review of the p	ohysician's orders for					
	1	hrough May 2011					
		were physician's order					
		t to receive Remeron					
	, ,	nere was no physician's					
	order to discon	tinue the Remeron.					
	Review of the i	medication					
		records for January					
		May 2011 indicated the					
	resident contin	ued to receive					
	Remeron 30 m	g at HS daily.					
	Dovious of the	Social Progress Notes					
		ntry dated 3/20/11. The					
		Director did not					
		orogress notes that the					
	I -	s no longer seeing the					
	1	at the psychiatrist					
		sident was no longer					
	receiving Rem						
	Interview with t	the Social Service					
		8/11 at 3:15 p.m.,					
		as not aware the					
	1 ' '	d written the progress					
	note dated 2/2	2/11 that indicated the					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE (COMPL 05/20/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			FTH ST		
		REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	<u> </u>	o longer receiving		1110			DITTE
	Remeron and would no longer be						
	seen by the psychiatrist. He also						
		ne knew the resident					
	continued to re	ceive the					
	antidepressant	medication.					
	Review of the	Behavior Book					
	indicated there	was a behavior sheet					
	revised on 4/7/	10 that indicated the					
		hysically abusive,					
		opriate and combative					
		resists care at times					
	and instigates	otners.					
	Interview with	CNA #2 on 5/19/11					
	12:25 p.m., ind	licated she was familiar					
		nt and has never seen					
	combative beh	avior exhibited by her.					
	Interview with	Social Service Director					
	on 5/19/11 at 1	2:45 p.m., indicated					
		neet in the Behavior					
	Book was not i						
		ent status. He states he					
		r sheets in the book for					
	1 -	left Resident #8's in					
		longer. He states the combative or physically					
		dicated that the					
		ues to receive the					
		Remeron, and there					
		sheet in the Behavior					
	Book for monit	oring the resident's					
		ptoms of depression.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155458	B. WIN			05/20/20)11
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				FTH ST		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0253	in the Behavior symptoms of de 3.1-34(a)						
SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interviews, the facility failed to ensure the residents' environment was clean and in good repair related to marred door frames, marred walls, discolored caulking around the tile in the bathrooms, and missing baseboard for 2 of 2 hallways, 4 of 4 bathrooms, and for 1 of 1 Dining Rooms. (The front and back hallways, Bathroom #1, #2, #3, #4, and the Main Dining Room) This had the potential to effect 29 residents. Findings include: During the Environmental tour on 5/19/11 at 1:15 p.m., the following was observed: A. The paint was chipped on a 12		F0	253	Preparation and/or execution of this plan not constitute admission or agreement by provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 253- Housekeeping & Maintenance services. (a) What corrective action(s) be accomplished for those resid found to have been affected by practice: a) The area around the sink in R 5 was sanded and painted. b) Room 7 was patched and pained: c) The door frame in room 8 was sanded and painted. The chair was replaced. d) The closet door in room 9 was painted. e) Room 10 was painted. The corrective action(s) the coverbed light was replaced. f) Room 11 was painted including area by the window and the floor by the wall.	will lents the Room nted. as vas as cord leed. ng the	06/19/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLE	ETED
		155458	B. WIN			05/20/20)11
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	FTH ST		
нісні лі	ND NI IDSING AND	REHABILITATION CENTER		1	AND, IN46322		
	NO NONSING AND	REHABIEHATION CENTER		TIIGHE	110, 1140322		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG	.	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	who resided in the Room				g) The closet door in room 17 v		
					cleaned and painted including the	he	
	B. The wall be	hind the head of the			area beneath the doors.		
	bed for bed "C"	" was marred and in			h) Room 15 was painted includ the above the heater and above	-	
	need of paintin	g and there was a 6			window. The cove base was	uie	
	-	he wall behind the bed			replaced.		
	in Room 7. Th				i) The cove base in room 18 wa	s	
		resided in the Room.			repaired. The wall behind bed		
	100idCiilo Willo	rediaca in the recoin.			patched and painted.		
	C In Doom 0	the room door froms			j) The tile in bathroom #2 was		
		the room door frame			thoroughly cleaned. A new doo	or is	
		and marred. The arms			ordered.		
	_	traight chair in the			k) A new door was ordered for		
		atched and marred and			west exit. The corners were cle		
	was in need of	varnish. There were			l) The wall below the chair rail		
	two residents v	vho resided in the			Main dining room was cleaned painted. The trim was installed	and	
	room.				around the closet door.		
					m) The caulking was replaced		
	D. In Room 9.	there was a three foot			around the toilet in bathroom #	1. The	
	· ·	closet door that was			door frame was repaired and pa		
		ratched. There was			The bathroom was painted and		
		ho resided in the room.			cove base repaired.		
	One resident w	no resided in the room.			n)The wall tile in bathroom #4		
		the entire well by head			thoroughly cleaned. The kick pl	late	
), the entire wall by bed			on the door was cleaned.		
		d. There was also no			o)The kick plate on the door to		
	1	to the over bed light.			bathroom #3 was cleaned. p) The main entrance/exit door	Wood	
	There was one	resident who resided			sanded and painted and the fran		
	in the room.				was repaired and painted. The		
					corners were cleaned. The wall	lpaper	
	F. In Room 11	, the entire wall was			in the back hallway was remove		
	marred and ch	ipped by window near			the wall painted.		
		he floor box by the wall.					
	_	o residents who resided			(b) How you will identify of	her	
	in the room.				residents having potential to b		
					affected by the same practice a	and	
	O In Date 45	7			what corrective action will be		
] G. IN KOOM 1/	7, there were black	ı			1	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		A. BUII	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2011			
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	marks on the bedoor and the well closet door, this foot of the wall. residents who residents who residents was missinch piece of cocloset door was by three inch as the window had two residents we room. I. In Room 18, pulled away from foot section of the wall behind becomed of repair. The residents who reside	ottom of the left closet all corner near the swas the bottom one. There were two resided in the room. It a one inch by five the wall above the sing paint. A three ove base near the smissing. A five foot rea of the wall above in o paint. There were who resided in the wall and a one the lower part of the id 2 was cracked and in There were two resided in the room. It had discolored the bathroom floor in a. The caulking was in color all around the por was splintered door d had chipped wood. It is to affect 15 were capable of using the color was rusted and in the facility.		TAG	taken: Residents residing in the facility the potential to be affected but a specific resident was identified. (c) What measures will be printo place or what systematicy changes you will make to ensure that the practice does not record Maintenance Director has been inserviced as to the required components of this tag. The standard monitoring and an needed adjustments identified with during routine environmental reand monthly preventative maintenance rounds as the Maintenance Director checks for environmental issues including not limited to cove base, paint, and door frames and Bathroom. (d) How the corrective action will be monitored to ensure the practice will not recur, i.e., why quality assurance program will put into place: The monitoring of this tag will joint effort between the NHA at Maintenance Director as they were make weekly walking rounds for next four weeks and bi-monthly months as they review the environmental appearance of regrooms, common areas and bathrooms. A Report of their firm will be discussed at the monthly Management/QA meeting to determine when compliance has a standard to the process of the standard to the standard to determine when compliance has a standard to the	no not not not not not not not	DATE	
		orners were dirty with			met and quarterly monitoring b Regional Director of Plant	y the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		LDING	NSTRUCTION 00	(X3) DATE COMPI 05/20/2	LETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A	DDRESS, CITY, STATE, ZIP CODE FTH ST ND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	dirt build up.			Operations/Designee is recommended.		
	in Main Dining black scuffs no missing all arouthe main dining. M. The toilet cowas discolored the toilet in Bat bathroom door gauged around walls were mar and a 3 foot see	aulking was rusty and orange/black around hroom #1. The was marred and the door frame. The red in the bathroom ection of base board ay from the wall. This		recommended. (e) Date of compliance: 6/1	9/11	
	residents who we the four bathroom N. The wall tile the shower room three foot section discolored black the door was marks. This has 15 residents who was ing the four the facility. O. The kick place	were capable of using oms in the facility. e in the Bathroom #4 in m was discolored. A on of grout was k. The kick plate on narred with black d the potential to affect no were capable of pathrooms in the				
	This had the porcesidents who	Bathroom #3's door. Intential to affect 15 Invere capable of using the some in the facility.				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
		155458	A. BUI B. WIN	LDING IG		05/20/2	2011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	P		DDRESS, CITY, STATE, ZIP CODE		
				9630 FII			
		REHABILITATION CENTER		<u>l</u>	ND, IN46322		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	J SE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
	marred and the around the door frame was also black dirt obset the door. The hallway by the and scuffed with the literal with literal with literal with literal with literal with literal with literal with litera	Maintenance Director at d all of the above was in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPL	ETED
		155458	B. WING	ino		05/20/2	011
			l	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			9630 FIF			
HIGHLAN	ND NURSING AND	REHABILITATION CENTER			ND, IN46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PR	REFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	7	TAG	DEFICIENCY)		DATE
F0278 SS=A	The assessment nesident's status.	nust accurately reflect the					
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.						
	A registered nurse the assessment is	must sign and certify that completed.					
	the assessment m	no completes a portion of sust sign and certify the ortion of the assessment.					
	Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.						
	material and false Based on obse and interview, t accurately com Data Set (MDS 16 residents wh assessments w sample of 25. (Findings includ Observation on	rvation, record review the facility failed to plete the Minimum) assessment for 1 of mose MDS vere reviewed in a Resident #3)	F027	78	Preparation and/or execution this plan does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set for on the statement of deficiency. This plan of correction is prepared and/or executed so because required. F 278Comprehensive Assessments (a)What correct action(s) will be accomplished those residents found to have been affected by the practice oral assessment was completed.	the cts rth ies. lely ctive d for e : An	06/19/2011

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155458 05/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9630 FIFTH ST HIGHLAND NURSING AND REHABILITATION CENTER HIGHLAND, IN46322 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE missing and broken teeth. for resident #3. A modification of the most recent comprehensive MDS was performed to correct The record for Resident #3 was information related to Oral reviewed on 5/18/11 at 1:05 p.m. The Status. (b)How you will identify resident's annual Minimum Data Set other residents having (MDS) assessment, with the potential to be affected by the same practice and what assessment reference date of corrective action will be taken: 11/17/10, was reviewed. The All active residents have received Oral/Dental Status portion of the an updated oral assessment. The assessment indicated the resident most recent comprehensive MDS had no broken natural teeth. assessment for all active residents has been reviewed to ensure that the oral assessment Interview with LPN #3 on 5/18/11 at findings are accurately coded on 9:40 a.m., indicated the resident has the MDS. Any corrections missing and broken teeth. needed were completed using the modification process per the RAI manual. (c)What measures will Interview with the MDS Coordinator be put into place or what 5/18/11 at 10:31 a.m., indicated the systematic changes you will MDS was inaccurately coded. She make to ensure that the indicated the resident's broken teeth practice does not recur: The should have been coded on the MDS. MDS coordinator has been educated on Chapter 3 (section L) of the RAI manual on Oral 3.1-31(d)assessment and MDS coding of Oral Status on the MDS. (d)How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: DNS or designee will randomly audit at least 5 residents' charts weekly times 4 weeks and then monthly for 2 months to ensure the MDS coding for Oral Status accurately

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reflects the residents' current oral

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155458	A. BUILDING	00	COMPLETED 05/20/2011
		100400	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/20/2011
NAME OF P	PROVIDER OR SUPPLIER			IFTH ST	
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		AND, IN46322	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
				CROSS-REFERENCED TO THE APPROPRIAT	TE
F0279 SS=D	A facility must use assessment to developed base comprehensive range of motion	velop, review and revise the nensive plan of care. evelop a comprehensive resident that includes rives and timetables to meet al, nursing, and mental and is that are identified in the sessment. St describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that it e required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). revation, record review the facility failed to plan had been assessment related to an and limitations for 1	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	NS or dit nice reterly by the on e: of 06/19/2011 the cts rth cies.
	motion of the 7	eviewed for range of who met the criteria tion. (Resident #19)		because required. F 279 – Comprehensive Care Plan (a)What corrective action will be accomplished for those	on(s)

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDDIG	00	COMPL	ETED
		155458		LDING		05/20/2	011
			B. WIN		ADDRESS CITY STATE ZIR CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
	ND NI IDONIO AND	DELLA DIL ITATIONI GENITED			FTH ST		
HIGHLA	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include:		İ		residents found to have bee	n	
					affected by the practice: A c	are	
	On 5/17/11 at 10:2	20 a.m., Resident #19 was			plan for a Restorative Rang	e of	
	observed sitting (up in a Broda chair. His left			Motion program was		
	hand was closed	in the shape of a fist with a			implemented for resident #	÷ 19	
	rolled up washcloth noted.				as it pertains to contracture		
					management. (b)How you		
	On 5/17/11 at 2:00 p.m., the resident was in				identify other residents ha	ving	
		l was closed with a rolled			potential to be affected by	the	
	washcloth noted.				same practice and what		
					corrective action will be ta	ken:	
	1	0 a.m. and 11:30 a.m., the			A comprehensive audit of th	e	
		ng in a Broda chair. His left			medical records for all active	е	
	hand was closed and had a rolled washcloth				residents' who have contrac		
	in it.				was conducted to ensure th	at a	
	The recent for De	saidant #40 was reviewed an			plan of care addressing the		
		esident #19 was reviewed on			contracture as appropriate i		
	5/18/11 at 2:17 p.	.m.			present. (c)What measures	will	
	Povious of the 2/0	/11 Annual Minimum Data			be put into place or what		
		sment indicated the resident			systematic changes you w	ill	
		n staff for Activities of Daily			make to ensure that the		
		nge of motion and limitation			practice does not recur: The		
		ne side of his upper and			MDS coordinator was educa		
	lower extremities.				per Chapter 4 of the RAI ma		
		•			as it pertains to the develop		
	Review of the Ca	re Area Assessment ADL			of the comprehensive plan		
	worksheet indicat	ted "Resident has left sided			care. (d)How the correctiv		
		s non-ambulatory needs			action(s) will be monitored		
	, ,	r all ADL's. He makes no			ensure the practice will no	τ	
	attempts to transf	fer without assist. Vision is			recur, i.e., what quality		
	lost in left eye but	t room is set up to			assurance program will be	-	
	accommodate thi	s."			into place: DNS or designe	e will	
					randomly audit at least 5	4	
	1	rent 5/11 care plan indicated			residents' charts weekly tim		
	the resident's range of motion and/or limitations to his left hand were not addressed. Review of Occupational Therapy notes dated				weeks and then monthly for		
					months to ensure care plans		
					addressing range of motion		
					needs are present as appro	priate	
					and representative of the resident's needs and condit	ione	
		e resident had a contracture			The DNS or designee will re		
	to his left hand ar	nd elbow and was being			The Divo of designee will re	;purt	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CORRECTION	155458	A. BUILDING	00	05/20/	
		100100	B. WING	EET ADDRESS, CITY, STATE, ZIP COD		2011
NAME OF P	ROVIDER OR SUPPLIER) FIFTH ST	L	
HIGHLAN	ND NURSING AND I	REHABILITATION CENTER		HLAND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE ROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		4l- l	DATE
	Maintenance Plan implemented and i Patient was dischadue to Patient requisplints on. Patient patient, to be dc'd splint secondary phas achieved max Interview with the 5/19/11 at 2:30 p.m.	instruct staff and family. larged from OT on 8/14/10 larged from OT on 8/14/10 larged from OT on 8/14/10 larged from OT on 8/14/10 larged from OT on 8/14/10 larged from OT on 8/14/10 larged from OT on splints, larged from OT on the staff of the		their audit findings at the Risk Management\Qua Assurance committee us continued compliance is continued compliance is Quarterly oversight will completed by the Region Director of Utilization Review (e)Date of comp6/19/11	lity ntil s met, until s met, and be onal	
F0309 SS=D	must provide the note attain or maintain physical, mental, and in accordance with assessment and placed on observant interview, to ensure each resonance eac	st receive and the facility secessary care and services in the highest practicable and psychosocial well-being, a the comprehensive lan of care. Invation, record review the facility failed to sident received the sment and services assessment of skin and for 2 of 3 residents the criteria for other (Residents #32 & #37)	F0309	Preparation and/or exect this plan does not constit admission or agreement provider of the truth of talleged or conclusions se the statement of deficien plan of correction is prepand/or executed solely be required. F 309 Quality of Care Pr Care/Services for highest being	ute by the he facts t forth on cies. This pared ecause	06/19/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2011				
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BITE			
				(A)What corrective actions was accomplished for those reside found to have been affected by practice?	ents			
				Resident # 32 reassessed for b on Left hand with documentat source of bruise with notificat MD and family. No treatment obtained area will be monitore weekly on the TAR until resol Care plan reviewed and update the bruise. Weekly Skin Check updated to reflect current skin Resident # 37 reassessed for site tears with review of current treorders and proper MD /Family notification. Monitoring of his tears will be done daily/weekly the TAR until resolution. Care reviewed and updated. Weekly Check was updated to reflect of skin issues.	ion of ion to orders ed ution. ed for a was issues. kin eatment of skin y on plan of Skin			
				(b) How other residents have the potential to be affected by same practice will be identificand what corrective actions we taken?	y the ed			
				Facility audit was conducted or residents to identify any bruisi skin tears that had not been identified. Any issues identification were addressed and/or corrected.	ng or ed			
				(c) What measures will be pu place or what systemic chang will be made to ensure that tl	es			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP. 05/20/2	LETED			
		REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
				practice does not recur? Direct caregiver staff was on the facility standard an guidelines for reporting, sintegrity issues on 06/08/1 Licensed nurses will be reon 05/31/11 and 06/07/11 facility standard and guide reporting, assessment, does and follow-up of resident concerns especially skin to bruises. The facility management to review event reports, 24 h grievances and concerns of the Monday through Fridat meeting in order to investifullow-up on any skin concensure appropriate docum and follow-up have been of the monitored to ensure the practice will not recur and quality assurance prograput into place? DNS or Designee will and hour report 5 times week and then monthly for 2 admonths for any identified and will follow up in clinit to ensure timely MD /Fam notification and event report Skin Check sheets, TARs, plans for identification of and or bruising for treatme continued monitoring 3 tinx 4 weeks then monthly for 2.	d kin 11. seducated on the elines for cumentation skin ears and team will our reports, laily during sy stand up igate and scerns to entation completed. We actions he ad what sim will be lit the 24 x 4 weeks ditional skin issues cal record nily orting. Weekly and care skin tears ent and mes weekly			

PRINTED: 06/13/2011 FORM APPROVED OMB NO. 0938-0391

l li		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 05/20/	LETED			
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	#37 was observed wheelchair. The occlusive dress the top of the reof the knuckle a finger, and the calf area. The record for reviewed on 5/resident's diagred were not limited failure, essential blood pressure dizziness). The admitted to the A Physician's of the occlusive dresses of the control of the con	ere were clear sings noted to areas on esident's left hand, top area of the right middle outer side of the right Resident #37 was 17/11 at 2:31 p.m. The noses included, but d to, congestive heart fall hypertension (high) and syncope(additional months to excompliance. Results of these findin presented at the month Management \Quality meeting to determine it has been met and quart by the RDCO is recommended by the RDCO is recommended by the recompletes her syst which includes skin/wanagement. (e) Date of Correction	gs will be aly Risk Assurance of compliance terly oversight amended when em reviews ound				

000367

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/20/2	ETED	
		100 100	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 00:20:2	
NAME OF	PROVIDER OR SUPPLIEI	2			FTH ST		
		REHABILITATION CENTER		1	AND, IN46322		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	+	uckle with normal	+	ing	<u> </u>		DATE
	•	dry dressing every 72					
	1 '''	eeded until the area					
	healed. The order was changed on 5/2/11 to cleanse the area with normal						
	saline, apply o	cclusive dressing every					
	7 days and as	needed until healed.					
	A Physician's o	order was written on					
	5/7/11 to clean	se the skin tear to the					
	side of the righ	t calf with normal					
	1	cclusive dressing every					
	7 days and as	needed until healed.					
	A Physician's o	order was written on					
	5/16/11 to clea	nse the skin tear to the					
	top of the left h	and with normal saline					
		usive dressing every 7					
	days and as ne	eeded.					
	The 5/11 Nurse						
	1	entry in the 5/2/11					
		made at 9:30 p.m.,					
		n tear to the resident's					
	"	ckle area measuring					
	1 ,	neters) x 2.0 cm. with					
		e resident stated he ne side of the doorway.					
	1	on 5/3/11 at 11:00					
	1	a new order was					
	1	e right middle finger					
	1	try made on 5/3/11 at					
	1	cated the dressing to					
	•	le was clean, dry, and					
	1 -	y made on 5/4/11 at					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MUI	TIPLE CO	NSTRUCTION		(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILE	DING	00		COMPL	
		155458		B. WING				05/20/2	U11
NAME OF I	PROVIDER OR SUPPLIER	*	•			DDRESS, CITY, ST	ATE, ZIP CODE		
					9630 FII				
HIGHLAI		REHABILITATION CENTER			HIGHLA	ND, IN46322			
(X4) ID		STATEMENT OF DEFICIENCIES			ID		PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		P	REFIX	CROSS-REFERENC	VE ACTION SHOULD BE CED TO THE APPROPRIAT FICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)			TAG	DE	FICIENCY)		DATE
	l	licated the treatment to							
	_	le continues. There							
		r ongoing assessment							
		in the 5/11 Nurses'							
	Notes.								
	1	5/16/11 Nurses' Notes							
		e at 2:00 p.m., indicated							
		served to the to the left							
		ig 2.7 cm. x 0.1 cm.							
	with a small an								
	. •	us drainage and no							
		oms of infection. The							
		ed the writer he							
	1	ea on a weight in							
	therapy. An er	ntry made in the							
	5/16/11 Nurses	s' Notes at 6:00 p.m.,							
	indicated the d	ressing to the left hand							
	was clean, dry,	, and intact. There							
	were no further	r ongoing assessments							
	of the skin tear	in the 5/11 Nurses'							
	Notes.								
	An entry in the	5/7/11 Nurses' Notes							
	made at 6:15 p	o.m., indicated the CNA							
	alerted the Nur	rse to an area on the							
	resident's right	calf and a skin tear							
		cm. x 1.8 cm. was							
	observed. The	resident indicated he							
	bumped it on h	is walker and staff							
	were to continue to monitor. There was no further documentation of								
assessments of the right calf skin tear in the Nurses' Notes from 5/8/11									
	through 5/15/1								
FORM CMS-2	2567(02-99) Previous Version		1XZ	 ZS11	Facility I	D: 000367	If continuation sh	neet Par	ge 61 of 110

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE COMPL		
		155458	A. BUI B. WIN	LDING IG		05/20/2	011
			р. үүл		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER			9630 FI	FTH ST		
HIGHLAND NURSING AND REHABILITATION CENTER				HIGHLA	AND, IN46322		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
1710	REGELITORI OR	ESC IDENTIFY TINO IN ORGANITORY	+	1110			Ditte
	A care plan initi	ated on 4/21/11					
	•	sident had disruption					
		ace not related to					
	pressure with s	kin tears noted the					
	lower and uppe	er extremities. Care					
	plan approache	es included staff were					
	to complete the	· Weekly Skin					
		onitor for signs and					
		fection or delayed					
	_	redness and drainage					
		Staff were also to					
	· ·	care as ordered and					
		ectiveness of and					
	response to the	e ordered treatment.					
	 The 5/11 Week	ly Skin Review sheet					
		Entries were made on					
	5/3/11, 5/10/11,	5/13/11, and 5/14/11.					
	All of the above	e entries were					
	completed by li	censed nursing staff					
		entries all indicated					
		of skin impairment"					
	were noted. Th						
		of the above skin tears					
		s of the above skin					
		eekly Skin Review					
	assessment.						
	 When interview	red on 5/18/11 at 2:40					
		or of Nursing indicated					
	•	not have a clear cut					
	•	ng assessment of non					
		areas. The Director of					
	Nursing indicate	ed there should have					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155.458			MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED OF (20/2011)				
		155458	B. WIN	G		05/20/2	2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		9630 FI	ADDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	areas and the v not address an areas. 2. Resident #32 5/17/11 11:10 a wheelchair. The left hand that w size.	essessments of the veekly skin sheets did assessment of the 2 was observed on .m. seated in her ere was a bruise on her as 1 inch by 1 inch in					
	reviewed on 5/7 Nurse's Notes of the entries in documentation resident's left here of 5/6/11, indicated no do	Resident #32 was 18/11 at 1:05 p.m. The were reviewed. There the Nurse's Notes rough 5/7/11. Review dicated there was no of a bruise on the and. Review of the ekly Skin Review" with 5/7/11 and 5/13/11 cumentation of the e on her left hand.					
	1:33 p.m., indic documented in followed up for She indicated b	PN #3 on 5/17/11 at ated bruises are to be the Nurse's Notes and 24 hours or 72 hours. The ruises could be at the Weekly Skin at that time.					
	on 5/18/11 at 2 new skin area s	ne Director of Nursing 40 p.m., indicated if a such as a bruise is to document on the					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155458	A. BUII	LDING	00	05/20/2	
		155456	B. WIN	_		03/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	UD NILIDOINIO AND I	DELIABILITATION OFNITED	9630 FIFTH ST				
HIGHLAND NURSING AND REHABILITATION CENTER				HIGHLA	AND, IN46322		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	weekly skin rev						
		e nursing progress					
	notes. She indi						
		should include an					
		the skin concern which					
		e, the appearance and					
		the skin concern. She					
	also indicated t						
		that the physician and					
	•	family member were					
		rea. She indicated the					
	skin concern is to then be measured						
	and assessed v	weekly. An "Event					
	Report" is to be	completed with new					
	skin concerns.						
	Continued interv	iew with the Director of					
	Nursing on 5/18/	11 at 2:40 p.m., indicated					
	the bruise on Res	sident #32's hand had not					
	been assessed. Sl	ne indicated there should					
	be documentation	n in the Nurse's Notes					
	related to the asso	essment of the resident's					
	bruise and physic	cian and responsible					
	family notification						
	<i>y</i>	•					
	3.1-37(a)						
	· · · (··)						
To Care	A: 1	the comment to the t					
F0311	_	the appropriate treatment aintain or improve his or her					
SS=D		n paragraph (a)(1) of this					
	section.	L 20. ak (a)(1) 21 mile					

l l		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155458	A. BUILDING 00		COMPLETED 05/20/2011		
		100400	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF I	PROVIDER OR SUPPLIER	₹			IFTH ST		
		REHABILITATION CENTER			AND, IN46322		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	Based or	n observation,	F0	311	Preparation and/or executio this plan does not constitute	n of	06/19/2011
	record re	view, and			admission or agreement by t provider of the truth of the fa		
	interview	, the facility			alleged or conclusions set fo on the statement of deficience	rth	
	failed to	•			This plan of correction is		
	·	•			prepared and/or executed so because required. F 311 Mai	,	
	assistand	ce for oral			ADL's (a) What corrective		
	care for '	1 of 1			action(s) will be accomplishe those residents found to hav		
	residents	who met the			been affected by the practice	e :	
					Teachable moment was completed with CNA #1 rega	ırding	
	criteria to	or assistance			ADL care specifically oral ca		
	with Activ	ities of Daily			Screen sent to Therapy. (b) How you will identify other))	
	Living.	,			residents having potential t	to	
					be affected by the same practice and what corrective	' A	
	(Residen	t #21)			action will be taken: Reside		
					receiving oral care from CNA had the potential to be affect		
	Findings	includo:			no others were identified. (
	Findings	include.			What measures will be put	into	
					place or what systematic changes you will make to		
	On 5/19/	11 at 6:10			ensure that the practice do	es	
					not recur: Direct care staff received education on ADL of	are	
	a.m., CNA #1 entered				with specifics on oral care.	aio	
	Resident #21's room. The CNA indicated				Therapy to screen and estab		
					residents who could benefit t		
					additional education and/or training – with plan to train si	taff to	
		doing her			these and/or any specific		
	morning	rounds and			recommendations. (d) Hov corrective action(s) will be	v the	
					monitored to ensure the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2011
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER	STREET A 9630 FI	AND, IN46322	1
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
was checking the		practice will not recur, i.e., what quality assurance	
resident for incontinence at this time. The CNA checked the resident for incontinence at this time and provided the resident a urinal to use per the resident's request. The CNA did not provide any other ADL (Activities of Daily Living) care at this time. The next time the CNA entered the resident's room was at 6:55 a.m. The CNA removed the resident's			ace: ing with a s will be on he onal eview e of the
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1)	(ZS11 Facility l	ID: 000367 If continuation	sheet Page 66 of 110

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 0/2011	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 F	ADDRESS, CITY, STATE, ZIP FIFTH ST AND, IN46322	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	The CNA	next entered				
	the reside	ent's room at				
	9:00 a.m.	. The CNA				
	provided	incontinence				
	care and	dressed the				
	resident a	at this time.				
	CNA#1 then assisted					
	the resident into a					
	wheelcha	air in his				
	room. A	t 9:42 a.m.,				
	the CNA	indicated she				
	had finish	ned a.m. care				
	for the re	sident. The				
	CNA did	not provide				
	any oral o	care or offer				
	to set up	the resident's				
	toothbrus	sh or oral care				
	supplies	for him				
	througho	ut this time.				

l I		IDENTIFICATION NUMBER:	ľ	IULTIPLE CO ILDING	00		(X3) DATE (COMPL	
		155458	B. WIN				05/20/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER			AND, IN46322			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	(EACH CORRECTIV	LAN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCE DEFI	ED TO THE APPROPRIAT CIENCY)	TE .	DATE
	When into	erviewed on						
	5/19/11 a	t 9:55 a.m.,						
	CNA #1 i	ndicated she						
	was going	g to have to						
	shave th	e resident						
	later as s	he had not						
	complete	d that earlier.						
	When into	erviewed on						
	5/19/11 a	t 1:00 p.m.,						
	the CNA	indicated she						
	had gone	back in the						
	resident's	s room earlier						
	and the re	esident was						
	given his	electric razor						
	•	able to shave						
	on his ow	n. At this						
	time, the	CNA						
	indicated							
	complete	d the						
	•	S ADL care.						
FORM CMS-2	2567(02-99) Previous Versio	ns Obsolete Event ID:	1XZS11	Facility l	ID: 000367	If continuation sl	heet Pa	ge 68 of 110

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUII	LDING	NSTRUCTION 00	l` ′	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE FTH ST ND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	10:25 a.m resident's included, limited to congestive failure, and pressure A care plated of the care updated of the care indicated	#21 was on 5/17/11 at n. The diagnoses but were not anemia, we heart hd high blood an initiated on dicated had a care deficit. plan was last on 5/11/11.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUILDING B. WING		00	COMPI 05/20/2	LETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STR 963	30 FII	ADDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN46322	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	with pers	onal hygiene					
	and bathi	ing. Care					
	plan inter	ventions					
	included	for staff to					
	provide the	ne amount of					
	assistand	ce or					
	supervision the						
	resident required.						
	Data Set admissio indicated (Brief Inte Mental Si was 14. A	n assessment the BIMS erview for tatus) score A score of licated the was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 05/20/2011			PLETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 F	ADDRESS, CITY, STATE, ZIP COE IFTH ST AND, IN46322	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	When int	erviewed on				
	5/17/11 a	it 11:00 a.m.,				
	CNA #1 i	ndicated she				
	was assi	gned to care				
	for the re	sident. The				
	CNA indi	cated she				
	works the day shift					
	(6:00 a.m. to 2:00					
	p.m.) and	d has been				
	assigned	to care for				
	the reside	ent many				
	times. C	NA #1				
	"day shift get u resident was progotten up for brown the CNA indicated to some also indicated to some associated to some associ	rovided a.m. care and reakfast on her shift. ated a.m. care for the rovide pericare, wash ush his teeth. CNA #1 the resident needed sistance with and dressing				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY IPLETED 1/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 F	ADDRESS, CITY, STATE, ZIP C IFTH ST AND, IN46322	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	things on	his own such				
	as putting	g on his shirt				
	in the mo	orning.				
	When int	erviewed on				
	5/16/11 a	it 9:11 a.m.,				
		#21 indicated				
	staff did r	not help him				
	as neces	sary to clean				
	his teeth.	The resident				
	indicated	he had a				
		sh here and				
		he staff to set				
	it up for h	nim to use.				
	 When int	erviewed on				
	5/19/11 a	it 1:28 p.m.,				
		#21 indicated				
	he had n	ot received				
	assistand	ce to brush				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2011			
	PROVIDER OR SUPPLIER	IL : REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	his teeth	today. The					
	resident	stated staff					
	did not as	sk him or set					
	him up to	do it today.					
	5/20/11 a the Directindicated indicated should had provided resident to	for the for oral care ush his teeth daily.					
F0312 SS=D	of daily living rece to maintain good r personal and oral Based on obse and interviews, ensure that a re	unable to carry out activities ives the necessary services nutrition, grooming, and hygiene. rvation, record review the facility failed to esident who was staff for personal	F0312	Preparation and/or executior this plan do not constitute admission or agreement by the provider of the truth of the faralleged or conclusions set for	the cts		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155458		(X2) MU A. BUILI B. WING	DING	TIPLE CONSTRUCTION (X3) DATE SUI NG 00 COMPLET: 05/20/201		ETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN46322		
HIGHLAN (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) hygiene received the appropriate services to maintain his Activities of daily living for 1 of 2 residents reviewed for Activities of Daily Living (ADL). (Resident #19) Findings include: On 5/17/11 at 10:20 a.m.,		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) on the statement of deficiency. This plan of correction is prepared and/or executed so because it is required. F-312 ADL Caford dependen	ies. olely	(X5) COMPLETION DATE
	sitting up in left hand was shape of a white wash On 5/17/11 resident was hand was o	19 was observed Broda chair. His as closed in the fist with rolled cloth noted. at 2:00 p.m., the as in bed. His left closed with a cloth noted.			Residents (a) What corrective action wi accomplished for those reside found to have been affected this practice: Resident # 19 we provided hand hygiene and trimming with placement of cowash cloth during survey by licensed nurse with assistant from assigned C NA. A teach moment for given to the assign C NA for the presence of dirt wash cloth rolled up in the Resident hand, lack of hand hygiene and dry skin present.	II be ents by vas nail lean a ce nable gned y	
	On 5/18/11 at 9:00 a.m., and 11:30 a.m., the resident was sitting up in a Broda chair. His left hand was closed and had a				How will you identify other residents having the potential be affected by the same practand what corrective action witaken: A comprehensive inspection of the Residents' finalls was conducted by nursion ensure they were clean and trimmed. No other residents were identified to be in need nail care. (c) What measures will be put into place or what systemic changes you will	etice, ill be finger ing to of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2011	
AND PLAN (CONTRICTION ROVIDER OR SUPPLIER SUMMARY'S (EACH DEFICIENT REGULATORY OR REGULATORY OR ROUSE OR ROUSE OR REGULATORY OR RE	REHABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) Sh Cloth in it. 11 at 9:45 A #2 was getting the out of bed. It was asked to the resident's Ith in his left the wash cloth colored yellow and the shand was re was a estance in his fingers. It indicated had not his hand yet		LDING IG STREET A 9630 FI		COMPLETED 05/20/2011 (X5) COMPLETION DATE Re ed by cility's are of d nails ut by How be ctice ace? onitor the as, Il s assure per line. dems orted auch
	today. F	ui ti lei				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MI A. BUII		NSTRUCTION 00	CON	TE SURVEY MPLETED 0/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDDRESS, CITY, STATE, ZIP CO FTH ST AND, IN46322		0/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	observati	on indicated					
	the reside	ent's					
	fingernail	s were very					
	long and	jagged.					
	Interview	with CNA #2					
	at that tin	ne, indicated					
	the reside	ent was					
	physically	y not capable					
	of cutting	his					
	fingernail	s. The CNA					
	indicated	she has not					
	personall	y cut his					
	fingernail	s. She					
	indicated	she had					
	thought t	he residents					
	get their	fingernails cut					
	on Sunda	ays					
	The reco	rd for					
	Resident	#19 was					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE S COMPL	
AND FLAIN	OI CORRECTION	155458		BUILDING	00		05/20/20	
			В. \	WING	DDRESS, CITY, STA	TE, ZIP CODE		-
NAME OF F	PROVIDER OR SUPPLIER			9630 FII	· · · · · ·	, 2.11 0032		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER	R	HIGHLA	ND, IN46322			
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID		LAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FUL! LSC IDENTIFYING INFORMATIO!		PREFIX TAG	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION DATE
	reviewed	on 5/18/11						
	at 2:25 p.m.							
	Review o	f the						
	quarterly	Minimum						
	Data Set	(MDS)						
	assessm	ent, dated						
	5/9/11, in	dicated the						
	resident v	was usually						
	understo	•						
		nderstands.						
	The resid							
	_	pendent on						
	ADL care							
	mobility,							
	locomotic	on, eating,						
	personal	hygiene, and						
	bathing.							
	Review o	f the current						
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event II	D: 1XZS	11 Facility I	D: 000367	If continuation sh	eet Pac	ge 77 of 110

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUI	LDING	NSTRUCTION 00	COM	TE SURVEY MPLETED D/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP OF STAND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	plan of ca	are dated					
5/9/11 indicated the							
	resident l	nas ADL self					
	care defic	cit he needs					
	assistand	e with					
	personal	hygiene one					
	assist. T	he nursing					
	approach	ies were to					
	provide o	nly the					
	amount c	of					
	assistand	e/supervision					
	that was	needed,					
	stand by,	cueing,					
	contact g	uarding and					
	weight be	earing,					
	explain a	Il procedures					
	and purp	ose prior to					
	performir	ng task and					
	encourag	je self					
	performa	nce.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUILDIN		00	COMPI	LETED	
		155458	B. WING	DEET A	ADDRESS, CITY, STATE, ZIP CODE	05/20/2	2011
NAME OF I	PROVIDER OR SUPPLIER		96	30 FI	FTH ST		
		REHABILITATION CENTER			AND, IN46322		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
	D	f Niversian a					
		of Nursing					
	Progress	notes for the					
	month of	May 2011					
	indicated	staff must					
	anticipate	e the					
	resident's	s needs.					
	There wa	is no					
	documen	tation the					
	resident i	efuses nail					
		'11 Nursing					
	Progress	•					
	Fiogress	NOICS.					
	Intoniou	with the					
	Interview						
		of Nursing on					
		t 11:00 a.m.,					
	indicated	nail care was					
	to be dor	e as needed					
	(prn) and	not					
	necessar	ily on					
		, -					
	L						L

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155458	A. BUILDING B. WING		05/20/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 F	ADDRESS, CITY, STATE, ZIP CODE IFTH ST AND, IN46322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Sundays.	She			
	indicated Sunday was				
	a good da	ay to do those			
	things be	cause there			
	were no s	showers on			
	that day.				
	3.1-38(a)(3)(E)				
F0315 SS=D	assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infection normal bladder fur Based on observand interviews, ensure there we resident who has catheter for 1 or and independent in the catheter for 1 or and independent who has catheter for 1 or and independent in the catheter for 1 or and independent independent in the catheter for 1 or and independent indepen	rvation, record review the facility failed to as a diagnoses for a ad an indwelling Foley f 3 residents reviewed ters of the 6 residents teria for Foley sident #19)	F0315	Preparation and/or execution of this plar not constitute admission or agreement by provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 315 Catheters (a) What corrective action(s) be accomplished for those resid found to have been affected by a practice: On 5/21/11 physician for reside 19 was notified that the ESBL identified as colonized and order received for discontinued of	will ents the nt # was

l l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155458	A. BUI B. WIN	LDING G		05/20/2011
NAME OF E	PROVIDER OR SUPPLIER	<u> </u>	P. 1111		DDRESS, CITY, STATE, ZIP CODE	
				9630 FII		
		REHABILITATION CENTER	_	<u> </u>	ND, IN46322	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E DATE
	On 5/17/	11 at 2:00			indwelling catheter since there l been no further drainage or pen	I
	p.m., Resident #19				edema noted. Resident # 19 had a new	
	· ·	erved in bed.			incontinence screen along with	3-day
					bladder diary completed withou	t
	At that tir	ne, there was			difficulty voiding. Care plan reviewed and revised	to
	a Foley o	atheter			reflect out come of the above ar	nd
	1				current interventions for inconti d/t DX of CVA w/dementia.	nent
	-	a dignity bag			Teachable moment given to lice	
	on the side	de of the bed.			nurse who failed to obtain diagr	
	5/18/11 a	ıt 9:00 a.m.,			meeting the criteria for indwelli catheter upon his readmission.	ng
	the reside	ent was sitting			(b) How you will identify oth	
		Broda chair.			residents having potential to b affected by the same practice a	
	· •				what corrective action will be	
	At that tir	ne, there was			taken: House-wide audit completed of	
	a Folev o	atheter in a			active residents who have curre	nt
	1	ag on the side			indwelling catheters to assure the appropriate diagnosis where pre-	I
		•			and met the suggested criteria for	
	of the cha	air.			315 indwelling catheter placeme	ent.
					Care plans where review and up if needed to assure that the diag	
	The same series	ual fau			was identified. Any issues were	
	The reco	ra tor			corrected upon identification.	
	Resident	#19 was			(c) What measures will be p	ut
	reviewed	on 5/18/11 at			into place or what systematic changes you will make to ensu	re
					that the practice does not recu	r:
	2:17 p.m				In-service education was provided t licensed nursing staff regarding obt	
	resident's diagnoses				an appropriate diagnosis for any residents admitted to the facility wi	th an
					indwelling catheter or obtaining orc	I
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID: 1	 XZS11	Facility I	D: 000367 If continuation sl	leet Page 81 of 110

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155458	A. BUII	LDING	00	COMPL 05/20/2	
		133436	B. WIN		A PARAGO CITY OT THE TIN CORE	03/20/2	011
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	included,	but were not			for and removing catheters if the re- does not have a diagnosis that requi		
	limited to	, urinary tract			its presence.	,	
	infection, stroke,				New admission charts will be revie at the regularly scheduled clinical	wed	
	·	•			meeting and orders will be reviewed ensure that residents who are admit		
	nistory of	prostate			with indwelling catheters have an	ied	
	cancer, a	ind urinary			appropriate diagnosis and that those residents without a need for the catl		
		•			have them removed within 24-hour	s after	
	reterition	•			admission after obtaining an order l attending MD.	by the	
	retention. Review of Nursing Progress Notes, dated 4/15/11 at 9:00 a.m., indicated the resident was exhibiting penile drainage, the resident's physician was notified and new orders were obtained. Physician orders,				attending MD. (d) How the corrective actio will be monitored to ensure the practice will not recur, i.e., wh quality assurance program will put into place: DNS/Designee will review 24 h report daily 5 x weekly x 4 wee then weekly times 2 months to identify any orders and placeme an indwelling catheter. The clin record will be reviewed including assuring diagnosis meeting the criteria for indwelling catheter placement and care plan revision have been addressed. Report of these findings will be reported at the monthly QA/Ris Management meeting until such substantial compliance as been and quarterly oversight by the Ris recommended when completing her system review which addressed.	n(s) e at ill be cour ks ent of ical ng n k n time met kDCO ng	
	dated 4/1	5/11.			has a focus on change of condit		
		a 16 french			(e) Date of compliance: 6/19	/11	

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		ONSTRUCTION 00	(X3) DATE S		
		155458	B. WIN	G		05/20/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	1	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NE.	DATE
	indwelling	g Foley					
	catheter	was ordered.					
	The resid	lent was then					
	admitted	to the					
	hospital o	on 4/20/11					
	and retur	ned to the					
	facility on	4/27/11 with					
	the Foley	catheter.					
	,						
	Review o	f the clinical					
	record in	dicated there					
	was no a	ssessment or					
		r the Foley					
		Review of					
		11 Physician					
	Order Sta	•					
		indwelling					
	Foley cat						
	Reason l						
	containm	ent ESBL.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
		155458	A. BUII B. WIN			05/20/2	011
NAME OF I	PROVIDER OR SUPPLIER	2		STREET A	DDRESS, CITY, STATE, ZIP CODE FTH ST	•	
HIGHLAI	ND NURSING AND	REHABILITATION CENTER		HIGHLA	ND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Control L month of indicated was read 4/27/11 fi the patho ESBL of it was co 4/27/11. Interview on 5/19/1 a.m., indi- was the re took the ophysician	the resident mitted on rom hospital ogen was the urine and lonized on with LPN #2 11 at 10:00 icated she nurse who order from the on 4/15/11 oley catheter.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	9630 FI	ADDRESS, CITY, STATE, ZIP C FTH ST AND, IN46322	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	resident	was not				
	5/19/11 a	of Nursing on at 10:30 a.m., there was no es for the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2011
NAME OF B	DOVIDED OD CUDDI IED		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/20/20
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	l l	IFTH ST	
(X4) ID		TATEMENT OF DEFICIENCIES	T ID	AND, IN46322 T	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ug regimen must be free	TAG	DEFICIENCY)	DATE
F0329 SS=D	from unnecessary drug is any drug w (including duplicat duration; or withou without adequate it the presence of ac indicate the dose s discontinued; or al reasons above.	drugs. An unnecessary when used in excessive dose the therapy); or for excessive at adequate monitoring; or indications for its use; or in diverse consequences which should be reduced or my combinations of the			
	resident, the facilit residents who hav drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose redu interventions, unle in an effort to disco	y must ensure that e not used antipsychotic n these drugs unless therapy is necessary to ndition as diagnosed and e clinical record; and antipsychotic drugs receive ctions, and behavioral ss clinically contraindicated, ontinue these drugs.	F0320	Preparation and/or execution of this	oplan 06/10/2011
	Based or	record	F0329	does not constitute admission or agreement by the provider of the tru	00/19/2011
		nd interview,		the facts alleged or conclusions set on the statement of deficiencies. Th	forth
	the facility	y failed to		plan of correction is prepared and/o executed solely because required.	r
	ensure th	iere was			
	adequate	indication for		F 329 Unnecessary Drugs (a) What corrective action(s) will	
	use of an	as needed		accomplished for those residents fo to have been affected by the practic	l l
	(prn) anti	anxiety		Issue #1 The active licensed nurses'	
	medication	on before it		responsible for Resident # 27 owhen PRN ativan given on	are
	was adm	inistered for 1		3-2-11,3-5-11, 3-15-11, 3-18-11 4-1-11, 4-16-11, 4-20-11, 4-23-	
of 3 residents			and 4-28-11 were re educated to) the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155458	B. WIN			05/20/2011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER		1	IFTH ST AND, IN46322	
					AND, 11140322	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	reviewed	for			importance of attempting and documenting planned interventi	
					and allowing time for effect pri-	I
	psychoad	tive			administering medications to re	
	medication	ons of the 5			behaviors. Also addressed was	
	residents who met the				Nurses Notes, Behavior Monito	-
					Form, documentation reconcile with the interventions attempted	
	criteria for psychoactive				that reflect the effect of each	
					intervention attempted on Nurse	
					Notes and Behavior Monitoring Form. Pharmacy consultant was	•
medications.					contacted to review current	
(Resident #27)				medications and assure appropr		
				diagnosis and interventions for		
	,				of the psychoactive medications appropriate for these Residents.	
					was reeducated per teachable	
	Findings	include:			moment on the behavior progra	
	•				including the monitoring of resi	l l
					receiving psychoactive medicat and antidepressants.	ions
	The reco	rd for				
l	Resident	#27 was			(b) How you will identify other	
	raviawad	on 5/17/11 at			residents having potential to be affected by the same practice and	what
	Tevieweu	on Sinin at			corrective action will be taken:	, white
	10:25 a.n	n. The			A comprehensive review was condito identify residents that present wi	
	resident's	s diagnoses			behaviors requiring a specific plan	of
		•			care, (including step-level-interven	
	included,	but were not			behavior monitoring sheet, and or/p medications for behaviors, agitation	l l
	limited to	, depression,			insomnia or anxiety. The DNS/Des reviewed resident clinical records a	~
		•			audited the last 90 days of pharmac	
	anxiety, a	and altered			recommendations. Pharmacy	ant wat
	mental st	atus			recommendations that were found addressed by the physician were	iot yet
	incinai si	atas.			forwarded to the physician upon	
					discovery.	

NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2011
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (C) What measures will be put into				STREET A	IFTH ST	1
(c) What measures will be put into	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	E COMPLETION
Review of Physician orders, dated 1/12/11, indicated Lorazepam (an antianxiety medication) 1 milligram (mg) one tablet three times a day (tid) prn for agitation. Review of the 3/11 Medication Administration Record (MAR) indicated the resident received the prn Lorazepam on 3/2 at 3:30 a.m., 3/5/11 at 2:00 a.m., 3/15/11 at 11:30 a.m., and on		orders, dindicated (an antia medication milligram tablet throday (tid) agitation. Review of Medication Administration (MAR) in resident prn Loraz at 3:30 at 2:00 a.m.	ated 1/12/11, Lorazepam nxiety on) 1 (mg) one ee times a prn for of the 3/11 on ration Record dicated the received the repam on 3/2 .m., 3/5/11 at ., 3/15/11 at		place or what systematic chang will make to ensure that the pradoes not recur: Licensed Nurses have been re edito the standard of investigating prantecedents (conditions that precipitate/exacerbate 'behaviors' may attempt to remove or reduce stressors that could be the source conflict for the resident. Licensed Nursing staff have been reeducat the standard of reviewing resident specific plans of care for interver (skip-level), known to be effective the importance of assuring nursing and BMF 's consistently reflect behaviors that occurred, interver attempted and the results of each intervention attempted prior to administering PRN (as needed) medications. Residents with new escalating behaviors will be discutted the AM standup meeting to allow interdisciplinary team an opportute evaluate and revise the current plus care. The team will perform a revisedents with new or exacerbate behaviors utilizing approved form 'Evaluation of New or Worsening Behavior'. Adjustments to the Plus care will be made following the completion of the evaluation for possible psychological, environmand psychosocial causes of behave exhibited. (d) How the corrective action be monitored to ensure the practical causes of behave exhibited.	es you actice ucated ossible) so they for a continuous section of the continuous section of th

NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Review of the back side of the MAR indicated there was no indication of why the medication was given. A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE RESPONSIBLE PATTERS OF this plan of correction will include the Director of Social Services and Director of Nursing Services with oversight by the RDCO. Random audits will be conducted on 5 records weekly to assure possible antecedents are investigated (If identified attempts to remove or reduce stressor are made), several resident specific behavior management interventions are attempted and results documented prior to the administration of PRN (as needed) medications. Immediate concerns will be addressed accordingly. Results of the	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Review of the back side of the MAR indicated there was no indication of why the medication was given. STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322 ID PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) DATI Place: The responsible parties for this plan of correction will include the Director of Social Services and Director of Nursing Services with oversight by the RDCO. Random audits will be conducted on 5 records weekly to assure possible antecedents are investigated (If identified attempts to remove or reduce stressor are made), several resident specific behavior management interventions are attempted and results documented prior to the administration of PRN (as needed) medications. Immediate concerns will be addressed accordingly. Results of the	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
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HIGHLAND NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Review of the back side of the MAR indicated there was no indication of why the medication was given. HIGHLAND, IN46322 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDDED BY FULL TAG DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE COMPLETED TO THE ACTION SHO	NAME OF I	PROVIDER OR SUPPLIER			1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3/18/11 at 10:45 p.m. PREFIX TAG (EACH DEFICIENCY) PREFIX TAG (EACH CON SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE DATION TO SOME TAGE TO SOME TA	HIGHLAN	ND NURSING AND	REHABILITATION CENTER		1			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 3/18/11 at 10:45 p.m. Review of the back side of the MAR indicated there was no indication of why the medication was given. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Place: Place: The responsible parties for this plan of correction will include the Director of Social Services and Director of Nursing Services with oversight by the RDCO. Random audits will be conducted on 5 records weekly to assure possible antecedents are investigated (If identified attempts to remove or reduce stressor are made), several resident specific behavior management interventions are attempted and results documented prior to the administration of PRN (as needed) medications. Immediate concerns will be addressed accordingly. Results of the								(X5)
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Review of the back side of the MAR indicated there was no indication of why the medication was given. correction will include the Director of Social Services and Director of Nursing Services with oversight by the RDCO. Random audits will be conducted on 5 records weekly to assure possible antecedents are investigated (If identified attempts to remove or reduce stressor are made), several resident specific behavior management interventions are attempted and results documented prior to the administration of PRN (as needed) medications. Immediate concerns will be addressed accordingly. Results of the		3/18/11 a	t 10:45 p.m.			place:		
Review of Nursing progress notes for the above mentioned dates indicated there was no documentation as to why the medication was given. There was no Behavior intervention Monthly Flow Record for review for the month of March.		Review of side of the indicated indication medication medication review of progress above medicated was no do as to why medication there was behavior Monthly for review	of the back e MAR there was no n of why the on was given. of Nursing notes for the entioned icated there ocumentation the on was given. as no intervention Flow Record w for the			correction will include the Director Social Services and Director of Nu Services with oversight by the RDC Random audits will be conducted or records weekly to assure possible antecedents are investigated (If ideattempts to remove or reduce stress made), several resident specific bel management interventions are atter and results documented prior to the administration of PRN (as needed) medications. Immediate concerns vaddressed accordingly. Results of the findings will be brought to the next Management/QA meeting to determ compliance is achieved and quarter oversight by the RDCO when she completes her system reviews which includes Physician notifications and dosage reductions is recommended	r of rrsing CO. on 5 Intified sor are havior intified will be the t Risk inne if rly ch d	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155.450		(X2) MU A. BUII		NSTRUCTION 00	COMPL	ETED	
		155458	B. WIN		A DODDEGG GUEV GEATE AND GODE	05/20/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE FTH ST		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Review o	f the 4/11					
	MAR indi	cated the					
	resident received the						
	Lorazepa	ım on 4/1/11					
	at 2:00 a.	.m., 4/16 at					
	4:00 p.m., 4/20 at 6:00						
	p.m., 4/23 at 10:30						
	p.m., and 4/28/11 at 6:30 p.m.						
	Review o	f the back					
	side of th	e MAR					
	indicated	there was no					
		as to why					
	•	nedication					
	was give	n. Review of					
	the Beha	vior					
	interventi	on Monthly					
	Flow Rec	ord indicated					
	the behav	viors of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	Ć	DATE SURVEY COMPLETED /20/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP COI FTH ST IND, IN46322	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	extreme t	fear and					
	panic we with a "0" behavior on the above medication medication medication medication was no dindicating medication 5/17/1 p.m., individed a result of the second medication of the second medicatio	re all coded 'meaning the did not occur ove d dates. If Nursing notes for the entioned icated there ocumentation g why the prn on was given.: with LPN #2 1 at 1:25 cated that esident is g a behavior					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE	LETED
		155458	B. WIN			05/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE FTH ST		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	medication	on they are					
	supposed	d to try at					
	least thre	e different					
	approach	es including					
	1 to 1 inte	erventions					
	and if they are						
	unsuccessful then they						
	give the prn						
	medication	on and					
	documen	t all that					
	information	on in the					
	chart.						
	Interview	with LPN #4					
	on 5/17/1						
		primarily					
	_	e 3-11 shift					
		the resident					
	yells out	loud					
	constantl	y all the time.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	9630 F	ADDRESS, CITY, STATE, ZIP CODE IFTH ST AND, IN46322	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	She indic	ated that she			
	has had t	o give the			
	resident the prn				
	medication	on on several			
	occasion	S.			
	3.1-48(a)(1)				
F0385 SS=G	a recommendation admitted to a facility remain under the of the facility must expressed on the facility must expressed on the facility must expressed on the facility must expressed on the facility of the fa	rvation, record review he facility failed to nding physician en a resident's change rranted a medical lated to penile swelling or 1 of 3 residents dwelling Foley e 6 residents who met ndwelling catheters.	F0385	Preparation and/or execution of plan does not constitute admiss; agreement by the provider of th truth of the facts alleged or conclusions set forth on the stat of deficiencies. This plan of correction is prepared and/or executed solely because require F385 - Resident care supervised by a physician A) What corrective action will be accomplished for those residents found to lead to the plant of the provided that the provided that the provided to the plant of the provided that	ion or e e ement e e e e e e e e e e e e e e e e e e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155458	B. WIN			05/20/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	2		1	FTH ST		
HIGHI AI	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	-	2:00 p.m., Resident	1		been affected by the		
		ved in bed. There was			practice?		
					Resident # 19's indwelling cath	neter	
	an indwelling Foley catheter drainage				has been discontinued as of 5/2		
	•	dignity bag hanging on			with no further drainage or peni		
	the side of the	bed.			edema noted, 3 day bladder dia		
					completed without difficulty vo		
	The record for	Resident #19 was			Resident remains incontinent du		
	reviewed on 5/18/11 at 2:17 p.m. The				Diagnosis of CVA with Dement		
	resident's diagnoses included, but				Care plan reviewed and revised		
	were not limited to, urinary tract						
	infection, stroke, history of prostate				LPN # 2 is no longer employed	by	
	cancer, and urinary retention.				the facility.		
	, , , , , , , , , , , , , , , , , , , ,				B) How will the facility identif	v	
	Review of Nursing Progress Notes,				other residents having the	J	
		at 9:00 a.m., indicated			potential to be affected by th	e	
		as exhibiting penile			same practices?		
		esident's physician was			An audit of the facility's 24 hou	ır	
	notified and ne				report records for the last 7 days		
					focus on change of conditions the		
	1	sician orders, dated			warranted MD notification and	a	
	4/15/11, indicate				clinical record review was	C	
	· ·	y catheter was ordered	completed. Any identified change of condition not addressed was				
	and to collect a				corrected.		
	1	sing Progress Notes,			Corrocted.		
	dated 4/15/11,	indicated the Foley			C) What measures will be put	into	
	catheter was in	serted with a clear			place to ensure the practice do		
	return of yellow	urine.			not recur?		
					Licensed nurses reeducated on t		
	The next docur	mented entries in			components of this regulation w		
		ess Notes were on			emphasis on the following: Star		
	1 -	p.m., 4/16/11 at 12:00			and guideline for Acute Change Condition with focus of notifica		
		t 9:00 a.m., 4/16/11 at			to MD timely of any condition	шОП	
	· ·	7/11 at 3:20 a.m.,			warranting a medical intervention	on	
		a.m., and 4/17/11 at			and the action to be taken if	011	
		•			attending physician non respons	sive.	
	6:00 p.m. The				Licensed nurses were reeducate		
	documentation	or assessment of the					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155458	B. WIN			05/20/2011	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
LIICHI M	ND NI IDOING AND	DELIADII ITATION CENTED		1	FTH ST		
		REHABILITATION CENTER		HIGHLA	AND, IN46322	_	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DAT	E
		s or any type of			the standards and guidelines for Charting and Documentation w		
	_	ose entries in Nursing			focus of acute condition change		
	Progress Notes	S.					
					D) How will the facility monito		
		ess Notes, dated			corrective actions to ensure th	nt	
	4/18/11 at 4:20 a.m., indicated				the deficient practice is being		
		d to below of penis			corrected and will not recur?		
	head. Will continue to monitor." The				DNS or Designee will review th	e 24	
	next entry was on 4/18/11 at 5:55				hour report daily at the morning		
a.m., which indicated the resident's					clinical meeting 5 times weekly	to	
physician was notified regarding the					identify any change of condition		
swelling to the penis, however, the				warranting a medical intervention	on.		
	physician stated he did not want to be				DNS or Designee will review 5	lv. for	
	called this early and to call back at				residents' medical records week 4 weeks then monthly for 2 monthly	· I	
	9:00 a.m. The	information was			to ensure that the resident's atte		
	passed on to the	ne day nurse.			physician has called back or		
					physically assessed a resident w		
	Nursing Progre	ess Notes, dated			24 hrs of notification of a chang		
	4/18/11 at 10:0	0 a.m., indicated the			condition or in such cases if this		
	Physician calle	d the facility back and			not occur that the Medical Direction has been notified to ensure the	etor	
	stated, "I'll be i	n today to see him."			resident's medical care is super	vised	
					Report of the above finding wil	l l	
	The next docui	mented entry in Nurse's			discussed at the next Risk		
	Notes was on	4/19/11 at 12:00 a.m.,			Management/QA meeting to		
	which indicated	d the resident had			determine if compliance has been	l l	
	penile discharg	ge. Nurse's Notes on			achieved and quarterly oversigh	t by	
	4/19/11 at 9:30	a.m., indicated there			the RDCO who will complete a system review with focus on ch	ange	
	was swelling a	nd redness noted to the			of condition is recommended.	inge	
	penis without of	Irainage. The					
	Physician was	notified of the swelling			E) Date of correction: 6/19/11		
	and redness ar	nd stated, "I didn't					
		erday. I'm definitely					
	coming in toda	y."					
		-					
	Nurse's Notes,	dated 4/20/11 at 12:00					

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	or connection	155458		LDING	00	05/20/2	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	FTH ST		
		REHABILITATION CENTER		1	AND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION DATE
IAG		there was drainage		IAG			DAIL
		and the head of the					
		len. Nurse's Notes,					
	dated 4/20/11 at 9:00 a.m., indicated "Copious amounts of yellow brown						
	purulent draina	ge noted from meatus.					
	Penis is red, sv	vollen and painful to					
	touch. MD (nai	me) aware, stated, 'I					
	swear I'll be the	ere today."					
	The next documented entry in Nurse's						
Notes was on 4/20/11 at 1:50 p.m.,							
		I the physician was					
		garding the penile ainage. The physician					
	1	another physician or					
	, , ,	n sometime this					
	evening."						
	Nurse's Notes,	dated 4/20/11 at 5:30					
	p.m., indicated	the physician was in to					
		t. At 6:15 p.m., the					
		ician gave orders to					
		ent to the hospital. At					
	' '	/20/11 the ambulance					
		ake the resident to the					
	hospital.						
	Review of the C	Consultation from the					
		4/21/11, indicated the					
	1 .	stal penile edema					
		arphimosis (is an					
	, , ,	dition which the					
		oulled back behind the					
		nnot be brought down					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	COM	TE SURVEY IPLETED D/2011	
NAME OF I	DROWIDED OR CLIDDLIE			EET ADDRESS, CITY, STATE, ZIP	CODE	
	PROVIDER OR SUPPLIEF			0 FIFTH ST		
HIGHLAN	ND NURSING AND	REHABILITATION CENTER	HIG	SHLAND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE	E APPROPRIATE	COMPLETION DATE
IAG	to it original po		IAG	BEI ICIENCI I		DATE
	to it original po	Sition).				
	Interview with I 8:30 a.m., indic having only per 4/15/11 and his at that time, she the doctor and collect a culture the penis. The the nurse work morning and the worse, it was a draining. The I time she called him and he indicated or penis was worse draining. She doctor and he aday. The LPN had made the I aware of both the physician. asked at what medical director the resident, she say I was instruindicated the resident on the physician.	LPN #2 on 5/19/11 at cated the resident was nile drainage on a penis was not swollen e indicated she called he gave orders to e of the drainage from LPN indicated she was ing on 4/19/11 in the resident's penis was swollen, red, and LPN indicated at the lathe doctor and told icated he would be in the interview with LPN in 4/20/11 the resident's se, swollen, red, and indicated she called the stated he would be that further indicated she called the stated he would be that further indicated she colirector of Nursing imes she had called The LPN was then point do you call the or and have him look at the indicated "I want to fucted not to." The LPN resident's penis had ince she first saw it				
	with discharge					
	Review of the	current and undated ledical Director of				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE (COMPL 05/20/2	ETED	
		155458	B. WIN			05/20/2	011
NAME OF F	ROVIDER OR SUPPLIER			9630 FII	DDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		1	ND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		ew Policy provided by					5.112
		Nursing indicated "As					
	much as possib	_					
	management w	ill first try to discuss					
		issues or concerns					
	•	practitioner. If such a					
	review is not fe						
	· ·	or if residents/patients e questions about a					
		ctions or orders, the					
	staff or manage						
	communicate w						
	director."						
	Interview with F	Director of Nursing on					
		a.m., indicated her					
		r the nurses were to					
	call the medica						
	resident's prima	ary physician had not					
		seen the resident					
		. She indicated she					
		aware of the situation					
		nen she looked at the					
	•	s and told the nurse get a hold of the doctor					
	immediately.	got a fiola of the addtol					
	3.1-22(a)(2)						

STREET ADDRESS, CITY, STATE, ZIP CODE 9830 FIFTH ST HIGHLAND, NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 9830 FIFTH ST HIGHLAND, NURSING AND REHABILITATION CENTER Disputable HIGHLAND, NURSING AND REHABILITATION CENTER HIGHLAND, NURGAG22 CKS) CMPLETON TAGE REGISTATION OF ISC DISTRITY NOR PRODUCTION OF ISC DISTRITY. THE ISC DISTRITY NOR PRODUCTION OF ISC DISTRITY NOR PRODUCTION OF ISC DISTRITY NOR PRODUCTION OF ISC DISTRITY NOR PRODUCTION OF	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JLTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPI		
NAME OF PROVIDER OR SUPPLIER INFO ID								05/20/2011	
HIGHLAND NURSING AND REHABILITATION CENTER HIGHLAND, IN46322 SUMMARY SYNTEMENT OF DEPICIFICIES PREFIX TAG SUMMARY SYNTEMENT OF DEPICIFICIES (EACH DEPICIFICY MUST BE PERCEDED BY FULL REGULATORY OR LNC IDENTIFYING INFORMATION) FO406 SS=D If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services from an outside resource (in accordance with §483.75(i) of this part) from a provider of specialized rehabilitative services. Based on observation, record review, and interview, the facility failed to ensure specialized rehabilitative services were obtained as ordered by the physician related to obtaining an occupational therapy evaluation. This affected 1 of 3 residents reviewed for accidents in the sample of 5 who met the criteria for accidents. (Resident #7) Findings include: Resident #7 was observed on 5/17/11 at 10:10 a.m., seated in a wheelchair in the dining room. Her right leg was in a cast and elevated on the leg rest. The record for Resident #7 was reviewed on 5/18/11 at 3:15 p.m. The resident was admitted to the facility				B. WIN		ADDRESS CITY STATE ZID CODE			
HIGHLAND, IN46322 IXA-1D SUMMARY SIATEMENT OF DETRICISCIES (2ACT DETRICINCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) FOUND (SS=D) IXA-1D SUMMARY SIATEMENT OF DETRICISCIES (2ACT DETRICINCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) FOUND (3S=D) IXA-1D SECONDAL DESCRIPTION OR SECONDAL DESCRIPTION OR SUMMARY SIATEMENT OF THE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) FOUND (3S=D) IXA-1D SECONDAL DESCRIPTION OR SUMMARY SIATEMENT OR SUMMARY	NAME OF P	ROVIDER OR SUPPLIER							
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO406 SS=D If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on observation, record review, and interview, the facility failed to ensure specialized rehabilitative services were obtained as ordered by the physician related to obtaining an occupational therapy evaluation. This affected 1 of 3 residents reviewed for accidents in the sample of 5 who met the criteria for accidents. (Resident #7) Findings include: Resident #7 was observed on 5/17/11 at 10:10 a.m., seated in a wheelchair in the dining room. Her right leg was in a cast and elevated on the leg rest. The record for Resident #7 was reviewed on on 5/18/11 at 3:15 p.m. The resident was admitted to the facility	HIGHLAN	ND NURSING AND I	REHABILITATION CENTER		l				
FO406 SS=D If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services sor mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services, or obtain the required services from an outside resource (in accordance with \$483.75(f) of this part) from a provider of specialized rehabilitative services. Based on observation, record review, and interview, the facility failed to ensure specialized rehabilitative services were obtained as ordered by the physician related to obtaining an occupational therapy evaluation. This affected 1 of 3 residents reviewed for accidents in the sample of 5 who met the criteria for accidents. (Resident #7) Findings include: Resident #7 was observed on 5/17/11 at 10:10 a.m., seated in a wheelchair in the dining room. Her right leg was in a cast and elevated on the leg rest. The record for Resident #7 was reviewed on 5/18/11 at 3:15 p.m. The resident was admitted to the facility	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
F0406 SS=D If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services from an outside resource (in accordance with §483-75(h) of this part) from a provider of specialized rehabilitative services. Based on observation, record review, and interview, the facility failed to ensure specialized rehabilitative services were obtained as ordered by the physician related to obtaining an occupational therapy evaluation. This affected 1 of 3 residents reviewed for accidents in the sample of 5 who met the criteria for accidents. (Resident #7) Findings include: Resident #7 was observed on 5/17/11 at 10:10 a.m., seated in a wheelchair in the dining room. Her right leg was in a cast and elevated on the leg rest. The record for Resident #7 was reviewed on 5/18/11 at 3:15 p.m. The resident was admitted to the facility						CROSS-REFERENCED TO THE APPROPRIAT	ΓE		
but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on observation, record review, and interview, the facility failed to ensure specialized rehabilitative services were obtained as ordered by the physician related to obtaining an occupational therapy evaluation. This affected 1 of 3 residents reviewed for accidents in the sample of 5 who met the criteria for accidents. (Resident #7) Findings include: Resident #7 was observed on 5/17/11 at 10:10 a.m., seated in a wheelchair in the dining room. Her right leg was in a cast and elevated on the leg rest. The record for Resident #7 was reviewed on 5/18/11 at 3:15 p.m. The resident was admitted to the facility			,	_	TAG	DEFICIENCY)		DATE	
on 1/17/11. The resident has diagnoses the included, but were not limited to, arthritis, diabetes and anemia. (b) How you will identify other residents having potential to be affected by the same practice and		but not limited to, p speech-language p therapy, and ment services for menta retardation, are rec comprehensive pla provide the require required services f accordance with § a provider of speci services. Based on obset and interview, t ensure specialis services were of the physician re occupational that affected 1 of 3 in accidents in the the criteria for a #7) Findings included Resident #7 was at 10:10 a.m., so in the dining roof in a cast and elements. The record for Reviewed on 5/2 resident was aco on 1/17/11. The diagnoses the in- limited to, arthrighted	cohysical therapy, coathology, occupational al health rehabilitative I illness and mental quired in the resident's an of care, the facility must ed services; or obtain the from an outside resource (in 483.75(h) of this part) from alized rehabilitative rvation, record review, he facility failed to zed rehabilitative obtained as ordered by elated to obtaining an erapy evaluation. This residents reviewed for a sample of 5 who met accidents. (Resident e: Is observed on 5/17/11 seated in a wheelchair om. Her right leg was evated on the leg rest. Resident #7 was 18/11 at 3:15 p.m. The dmitted to the facility e resident has included, but were not	F0	406	not constitute admission or agreement b provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 406 Provide/Obtain Specializ Rehab Services (a) What corrective action(s) be accomplished for those resid found to have been affected by practice: New order received to make ref for Occupational Therapy and Physical Therapy to Eval relayed the FRD. Nursing and staff reeducated on process for notifying therapy of therapy orders; FRD reeducated to review at morning meeting all new orders to those that are Therapy specif (b) How you will identify of residents having potential to be	y the or ed will ents the Ferral ed to Conew s, alert ic. her	06/19/2011	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURV		
AND PLAN	OF CORRECTION	155458	- 1	LDING	00	05/20/2011	
		100400	B. WIN		DDDEGG CITY OTHER TIN CODE	00/20/2011	
NAME OF I	PROVIDER OR SUPPLIE	₹		9630 FI	ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAI	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Ē	DATE
	T l	and the Sandle a Nicona da			what corrective action will be		
		entry in the Nurse's			taken: Physician telephone orders will	he	
		/8/11 at 9:30 p.m.,			reviewed for the past month of	I	
	_	sident returned from			and MTD for May to ensure all	· .	
		ass) with family			therapy orders have been carrie	d out	
	,	y member's name).			appropriately.		
		peen to (name of			() 3371 4 92 2		
		emergency room) d/t			(c) What measures will be p into place or what systematic	ut	
	1 ` ′	ile with family. While in			changes you will make to ensu	re	
	ER resident ha	•			that the practice does not recu	I	
		racture to right ankle.			DNS will bring the carbonless of	I	
		itly wrapped with ACE			of orders written to the next mo	~	
		s tender to touch.			stand up meeting to review with	I	
		esident what happened.			interdisciplinary team to ensure	I	
		d, "I was going to go to			new orders for therapy have been identified.	'n	
	, ·	ery store) when I			identified.		
		hile trying to go to the			(d) How the corrective actio	n(s)	
	car."" The	physician was notified			will be monitored to ensure th		
	of fall with frac	ture.			practice will not recur, i.e., wh	I	
					quality assurance program wi	ll be	
	There was an 2	X-ray report, dated			put into place:The correction will be a joint ef	Fort	
	5/8/11, that ind	icated, "Fracture of the			between the DNS/MDS/FRD w	I	
	distal fibula an	d tibia."			will review new orders with a		
					on therapy orders and their f/u.	This	
	There was a pl	hysician's order, dated			will be an on-going plan of		
	5/11/11, that in	dicated "PT/OT			correction with quarterly oversi	ght	
	(physical thera	py and occupational			by the Regional Director of		
	therapy) to eva	al (evaluate) and treat."			Rehabilitation. Report of the outcome of this plan will be		
					reviewed at the next monthly R	isk	
	Review of the	therapy notes indicated			Management/QA Meeting to		
		al therapy evaluation			determine if this has maintain		
	had been com				compliance or if additional		
					interventions need to be		
	Interview with	the Director of Nursing			recommended.		
		1:02 a.m., indicated					
		,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458			(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED D/2011
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		STREET A	DDRESS, CITY, STATE, ZIP CODE FTH ST AND, IN46322		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	O BE	(X5) COMPLETION DATE
	•	nal therapy had missed order to evaluate the			(e) Date of compliance:	6/19/11	
	Therapist on 5/ indicated she v	the Occupational /19/11 at 10:15 a.m., vas not informed of the er for an occupational tion.					
	Manager on 5/ indicated that r physician order communicated stated she was physician's ord	the Rehabilitation 19/11 at 10:20 a.m., eferrals to therapy and rs for therapy are verbally to her. She is not aware of the er for occupational uate the resident after cture.					
	5/19/11 at 10:5 was aware the process for nur physician's ord therapy staff. S resident was no	Director of Nursing on 0 a.m., indicated she at there was no formal rsing to communicate ers for therapy to the She indicated the ot evaluated by the herapist as ordered by					
	3.1-23(a)(1)						

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIM D	D.C.	00	COMPL	ETED
		155458	A. BUILDI B. WING	ING		05/20/2	011
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			9630 FIF			
HIGHLAN	ND NURSING AND	REHABILITATION CENTER			ND, IN46322		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	· ·	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
F0441 SS=D	Infection Control F a safe, sanitary ar and to help prever transmission of dis	establish and maintain an Program designed to provide and comfortable environment of the development and sease and infection.					
	Program under wh (1) Investigates, c infections in the fa (2) Decides what isolation, should b resident; and (3) Maintains a rea	stablish an Infection Control nich it - ontrols, and prevents					
	determines that a prevent the spread must isolate the re (2) The facility mu communicable dis lesions from direct their food, if direct disease. (3) The facility mu hands after each of the spread o	ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin t contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted					
	transport linens so infection. Based on record the facility faile Infection Control the lack of tube	andle, store, process and as to prevent the spread of or dreview and interview, do to maintain an or program related to erculin testing involving ethod at the time of	F 04 4	41	Preparation and/or execution of this plar not constitute admission or agreement by provider of the truth of the facts alleged conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because	y the or	06/19/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155458	B. WIN			05/20/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			FTH ST		
HIGHI AI	ND NURSING AND	REHABILITATION CENTER			AND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	,		(V.E.)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
		employee records			required.		
		ary Employee #1,					
	,	Employee #2 & CNA			F441 Infection Control		
		Limployee #2 & CNA			(a) Wilest commenting outline(a)	:11	
	Employee #3)				(a) What corrective action(s)be accomplished for those resid		
	<u>-</u>				found to have been affected by	CIIIS	
	Findings includ	e:			the practice:		
	 Employee files	were reviewed on			D		
		a.m. The following			Dietary employee #1,		
		a.m. The following			Housekeeping employee #2, and C.N.A. employee #3 had a repeature of the control o		
	was noted:				their Mantoux series	at 01	
	₅ . ,	<i>"</i> 4			their Mantoux Series		
		vee #1 was hired on			(b) How you will identify otl	her	
		erculin test was			residents having potential to b		
		n 3/25/11, the results			affected by the same practice a	ınd	
	of the testing w	as not documented. A			what corrective action will be		
	tuberculin test	was administered on			taken:		
	4/24/11, the res	sults were 0 mm				1.	
	(millimeters) a	negative result. There			No specific residents were foun be affected.	d to	
	was no docum	entation that a two-step			be affected.		
	tuberculin test	was completed for the			(c) What measures will be p	ut	
	employee.	·			into place or what systematic		
	' ' '				changes you will make to ensu	re	
	Housekeening	Employee #2 was			that the practice does not recu		
		. A tuberculin test was					
		n 1/24/11, the results			Facility Department Managers v		
		as not documented. A			re-educated on new hire process		
	1	was administered on			the importance of each employe completing their Mantoux series		
					BOM/NHA will monitor new hi		
		sults of that test were			ensure all paperwork is in place		
		d. A tuberculin test was			accurate, with a focus of the	===	
		n 5/4/11 the results of			Mantoux testing and results.		
		mm, negative. There					
		entation that a two-step			(d) How the corrective actio		
		was completed for the			will be monitored to ensure the		
	employee.				practice will not recur, i.e., wh		
					quality assurance program wil	ı be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155458	B. WIN			05/20/2	011
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	FTH ST		
HIGHLA	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	CNA Employee	e #3 was hired on			put into place:		
	1/26/11. A tube	erculin test was					
	administered o	n 1/26/11, the results			Monitoring of this will be by th		
		as 0 mm, negative. A			NHA as he performs random au		
		ulin test was not			for the next four (4) weeks on n		
	administered.				hire files to ensure completion of employee files which include	<i>7</i> 1	
		that a two-step			Mantoux tests If there are no n	ew	
		·			hires that week he will audit 2	''	
		was completed for the			random files weekly for the nex	t 30	
	employee.				days then every two weeks for t		
					next 2 months. Report of all audit		
	' '	d, "Tuberculosis,			be presented to the Risk manageme		
		eening for" dated			Committee to ensure compliance has been met an quarterly oversight by		
	_	vas provided by the			RDCO when she completes her sys		
	Director of Nur	sing on 5/20/11 at			reviews which includes infection co		
	11:45 a.m. She	e indicated the policy			is recommended.		
	was current. Th	ne policy indicated:					
					(e) Date of compliance: 6-19	9-11	
	All employees	shall be screened for					
		B) infection and					
	1	a two-step tuberculin					
		or blood assay for					
	, , ,	tuberculosis (BAMT)					
	1 -	· · ·					
		screening , prior to					
	beginning emp	ioyment.					
	The facility's F	mployee Health					
	1	Il administer a TST to					
		employees except					
	1						
		e documented positive					
		results and those who					
	l •	ented verification of					
	, ,	ive TST or BAMT					
	within the prec	eding 12 months.					
	Interview with t	the Administrator on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLI	
		155458	B. WING			05/20/20	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE FTH ST		
		REHABILITATION CENTER			AND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
1110		0 a.m., indicated the 3	1	1710		+	DAILE
		ployees had not					
	•	o-step method of					
	tuberculin testir	•					
		.9.					
	Interview with t	he Director of Nursing					
		1:45 a.m., indicated					
	the facility polic	y for two-step					
	tuberculin testir	ng had not been					
	followed.						
	3.1-14(t)(1)						
	3.1-18(k)						
F0518	The facility must tr	ain all employees in	l				
SS=C	emergency proced	lures when they begin to					
		periodically review the					
	unannounced staff	kisting staff; and carry out					
	procedures.	dillis daling those					
	Based on recor	d review and	F051	18	Preparation and/or execution of this plan		06/19/2011
	interviews, the	facility failed to follow			not constitute admission or agreement by provider of the truth of the facts alleged	· I	
	its emergency	preparedness policy			conclusions set forth on the statement of		
		ring there was more			deficiencies. This plan of correction is prepared and/or executed solely because	:	
		er drill policy book			required.		
	available for fac	cility staff's use.			F 518- Train all staff emergence	y	
					procedures/drills.		
	Findings includ	e:			() 1111 (.,,	
	Davieus of the co				(a) What corrective action(s) be accomplished for those resident		
		current emergency			found to have been affected by t		
	prepareuness p	policy book updated in			practice:		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155458	B. WIN			05/20/2	011
		1	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	FTH ST		
HIGHLA	ND NURSING AND	REHABILITATION CENTER		1	AND, IN46322		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	1	ID PROVIDED'S DI AN QE CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	2010 on 5/20/1	11 at 9:30 a m			A copy of the disaster manual w	vas	
		py of this plan shall be			placed at the Nursing Station.	Гће	
		certain areas of the			maintenance director has a copy	y and	
		ng but not limited to the			the DNS has a copy.		
	1	•					
		office, Nursing station,			(b) How you will identify of		
		ice Department.			residents having potential to b		
	' '	be made aware of the			affected by the same practice a what corrective action will be	and	
	location and th	e contents of the Plan."			taken:		
	 	N. #4 E/00/44 - 1 40 40			Residents residing in the facility	v have	
		N #1 on 5/20/11 at 10:10 e could not find the disaster			the potential to be affected but i		
	· '	urse's station, and did not			specific resident was identified.		
	know where it was						
					(c) What measures will be p	ut	
	Interview view the	Maintenance Director			into place or what systematic		
		a.m., indicated as far as he			changes you will make to ensu		
		nly one book, and he did not			that the practice does not recu		
	have one in his of	fice.			Maintenance Director has been		
	Interview with the	Administrator on 5/20/11 at			inserviced as to the required components of this tag.		
		ited there was only one book			Staff have been inserviced on the	ne	
		cility. He indicated he was			location of the disaster drill pol		
		eeded to be three books,			book.		
	and the book they	had was always kept in his			The standard monitoring and ar	ıy	
		locked when he was not in			needed adjustments identified v	vill be	
	the facility.				during routine environmental ro		
	0.4.54(-)				to assure copy is accessible at a	11	
	3.1-51(a)				times.		
					(d) How the compactive action	n(s)	
					(d) How the corrective action will be monitored to ensure the		
					practice will not recur, i.e., wh		
					quality assurance program wi		
					put into place:		
					The monitoring of this tag will	be a	
					joint effort between the NHA ar		
					Maintenance Director as they w		
					make weekly walking rounds for		
					next four weeks and bi-monthly		
					months as they review the locat	ion of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPI	
		155458	B. WING			05/20/2	011
NAME OF B	DOLUDED OD GUDDUED		<u>'</u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF P	ROVIDER OR SUPPLIER			9630 FI	FTH ST		
HIGHLAN	ND NURSING AND I	REHABILITATION CENTER		HIGHLA	AND, IN46322		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
					the books and quiz staff on their		
					knowledge of the location. A R of their findings will be discuss	_	
					the monthly Risk Management/		
					meeting to determine when	QЛ	
					compliance has been met and		
					quarterly monitoring by the Reg	gional	
					Director of Plant	-	
					Operations/Designee is		
					recommended.		
					(e) Date of compliance: 6/19)/11	
F9999					(c) Date of comphance. 6/12	/ 11	
1 ////							
	STATE RULES		F99	999	Preparation and/or executior	of	06/19/2011
					this plan does not constitute		
	3.1-14 PERSON	NEI			admission or agreement by t		
	3.1-14 I EKSON	NEL			provider of the truth of the fa		
	4 - 1 0 111				alleged or conclusions set fo		
	•	shall maintain current and			on the statement of deficience This plan of correction is	ies.	
	accurate personne				prepared and/or executed so	ılelv	
	employees. The p	personnel records for all			because required. F-9999 Fi	-	
	employees shall i	include: documentation			Observations Alzheimer		
	of orientation to	the facility and the			Training (a) What corrective		
	specific job skills	-			action(s) will be accomplishe	d for	
	-Perma joo simila				those residents found to hav	е	
	This state rule w	as not met as evidenced			been affected by the	ind C	
		as not met as evidenced			practice: Issue #1The identif N A job specific orientation	iea C	
	by:				checklist has been complete	d	
	.				and placed within the employ		
		reviews and interviews,			file. Issue #2 DNS obtained t		
	the facility failed				Alzheimer/Dementia educati	•	
	employees receiv	red a job specific			RDCO and began in-servicing		
	orientation upon	hire for 2 of 5 employee			staff, based on Indiana State		
	files reviewed. (Employees #1 and #4)			Guidelines.Employee #5 LPI	N, #6	
		,			C.N.A. #7 Housekeeper, #8 Housekeeper, #9 Occupation	nal	
	Findings include:				therapy aide, and #10 Physic		
	i mamas merade.	•			therapy all received their 3 h		
			<u>L</u>				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED
		155458				05/20/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER					
	ID 1111DOING 111D	DELLA DIL ITATIONI OFNITED		1	FTH ST	
HIGHLAN	ND NURSING AND	REHABILITATION CENTER		HIGHLA	AND, IN46322	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	The facility emp	loyee files were reviewed			annual training. (b) How you	u will
		0 a.m. A total of 5			identify other residents hav	ring
					potential to be affected by t	he
	employee files w	ere reviewed.			same practice and what	
					corrective action will be	
	Employee #1 wa	as hired on 3/28/11.			taken: An audit will be	
	There was lack o	f documentation for			conducted of facility personn	
	orientation to spe	ecific job skill as a			ensure that facility staff have	
	Dietary Aide.	3			completed job specific orient	ation
	Bietary rinae.				checklist on file. No specific	
	T 1 //4	1: 1 2/20/11 TI			residents were found to be	_
		s hired on 3/28/11. There			affected. (c) What measure	
	was lack of docu	mentation for orientation			will be put into place or who	l l
	to specific job sk	ill as a Certified Nursing			systematic changes you wi make to ensure that the	"
	Assistant.				practice does not recur: Do	ring
					new employee orientation the	·
	Interview with th	ne Administrator on			employee will be given a job	~
					specific orientation checklist	to be
		a.m., indicated the			completed within the first 30	
	employee files w	-			after hire and turned into his/	
	documentation th	nat job specific			supervisor Department	
	orientations were	e completed upon hire.			Managers were educated on	
					requirements for job specific	
	3.1-14(q)(7)				orientation · NHA and Nurs	·
	3.1 14(q)(7)				Administration were educate	d on
	0 4 44 DEDOO	NINITI			requirements for	
	3.1-14 PERSO	ININEL			Alzheimer/Dementia training	
					staff · Training will be prese upon hire (6 hrs) and annual	
	2. In addition to	o the required			hrs). · Sign in sheet was rev	
	inservice hours	in subsection (I), staff			to include the time, date and	
	who have regul	ar contact with			location, name and title of	
	_	have a minimum of six			instructor, and the program	
		mentia-specific training			content. The employee will	
	within six (6) m				acknowledge attendance by	
	, ,				written signature. (d) How	the
	· ·	r within thirty (30) days			corrective action(s) will be	
	for personnel a	•			monitored to ensure the	
	Alzheimer's and	d dementia special			practice will not recur, i.e.,	
	care unit, and t	hree (3) hours annually			what quality assurance	
			1		l	ı

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155458 05/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9630 FIFTH ST HIGHLAND NURSING AND REHABILITATION CENTER HIGHLAND, IN46322 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE thereafter to meet the needs or program will be put into place: The HFA/designee will preferences, or both, of cognitively conduct monthly audits of impaired residents and to gain personnel files of newly hired understanding of the current employees to ensure that a standards of care for residents with completed job specific orientation dementia. checklist has been completed. The findings of these audits will be brought to the monthly quality This state rule was not met as evidenced assurance/risk management meeting until such time as compliance has been determinedAdministrator will Based on record reviews and perform random audits for the interviews, the facility failed to ensure next four (4) weeks on in-service all employees were provided with records and new hire files to three (3) hours of dementia-specific ensure completion of required training annually, for 6 of 60 Alzheimer /Dementia training. The results of the random audits employee inservice records reviewed. will be reviewed at the next RM/QA meeting to determine if Findings include: substantial compliance has been demonstrated and that it is recommended that monitoring will The inservice forms for dementia be quarterly by the RDCO when training completed during the 2010 she completes her system year were provided on 5/20/11 by the reviews which includes new hire Director of Nursing for review. completion. (e) Date of compliance: 6-19-11 The individual employee inservice records and the dementia training attendance sheet for the year of 2010 were reviewed. Six of the 60 employees had not received three hours of dementia training during the vear of 2010. Employee #5 LPN hired on 5/12/01 Employee #6 CNA hired on 9/4/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155458		A. BUILDING	00 	COMP	LETED	
155458		B. WING 05/20/2011				
NAME OF PROVIDER OR SUPPLIER HIGHLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN46322			
	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B		1
TAG			TAG	CROSS-REFERENCED TO THE A	PPROPRIATE	DATE
PREFIX	Employee #7 H 6/22/09 Employee #8 H 3/14/91 Employee #9 C Aide hired on 6 Employee #10 hired on 2/21/0 Interview with the Consultant on 8 indicated not all	lousekeeper hired on lousekeeper hired on lousekeeper hired on loccupational Therapy l/12/06 Physical Therapist 6 he Corporate Nursing l/20/11 at 11:50 a.m., If the employees hours of dementia	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION